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ABSTRACT

The transcript of the March 28, 1980, Senate hearing on the Indian Health Service (IHS) and reauthorization of the Indian Health Care Improvement Act (Public Law 94-437) held in Billings, Montana, is presented with testimony from the Three Affiliated Tribes of North Dakota, Montana United Indian Association, Montana Indian Health Board, Fort Peck Tribe, Crow Tribe, Omaha Tribe of Nebraska, Northern Cheyenne Tribe, Fort Belknap, Flathead Tribe, and Devils Lake Sioux Tribe. Testimony is included on Public Law 93-638 (the Indian Self-Determination and Education Assistance Act), various aspects of IHS, Indian health services/facilities/programs, problems of reservation Indians and of Montana's urban Indians. Testimony includes requesting renewed funding for the American Indians Into Medicine (INMED) Program under Title I of Public Law 94-437, which provides for Indian health manpower development. Details are included on INMED, which is based at the University of North Dakota, and serves 22 reservations in North Dakota, South Dakota, Montana, Wyoming, and Nebraska. INMED is described as a program which identifies prospective medical career students from all grade levels and aids them in obtaining an advanced degree in the medical field. Appended are statements from Wind River Arapahoes and the National Urban Indian Council. (AN)

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INDIAN HEALTH SERVICE OVERSIGHT AND REAUTHORIZATION OF INDIAN HEALTH CARE IMPROVEMENT ACT

ED192964

HEARING

BEFORE THE

SELECT COMMITTEE ON INDIAN AFFAIRS
UNITED STATES SENATE

NINETY-SIXTH CONGRESS

SECOND SESSION

ON

OVERSIGHT OF INDIAN HEALTH SERVICE AND REAUTHORIZATION OF THE INDIAN HEALTH CARE IMPROVEMENT ACT

MARCH 28, 1980

BILLINGS, MONT.

Printed for the use of the Select Committee on Indian Affairs

U S DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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INDIAN HEALTH SERVICE OVERSIGHT AND REAUTHORIZATION OF INDIAN HEALTH CARE IMPROVEMENT ACT

MARCH 28, 1980

U.S. SENATE,
SELECT COMMITTEE ON INDIAN AFFAIRS,
Billings, Mont.

The committee met, pursuant to notice, at 1:20 p.m., in the city council chambers, Billings, Mont., Senator John Melcher (chairman of the committee) presiding.

Present: Senator Melcher.

Staff present: Max Richtman, staff director; Jo Jo Hunt, staff attorney; and Joe Meglen, field representative.

Senator MELCHER. The committee will come to order. I have a short opening statement to make.

Following the December 21 hearing, the committee hearing that we held here in Billings, the committee staff reviewed testimony pertaining to some of the questionable expenditures of Indian Health Service funds. I referred two of those questionable expenditures to the Attorney General for Justice Department investigation. Those two involved, first, the use of Federal funds to pay for private pilot training for the Billings area director of the Indian Health Service. The second item is the purchase and receipt of video equipment for the Indian Health Service office here in Billings prior to the requisition and purchase order approval.

I asked the Justice Department to determine if any legal authority exists for the use of Federal funds for private pilot training, and noted, in particular, that a contracting officer had requested that the purchase order for this training be canceled. Nevertheless, even though a contract officer recommended that the purchase order be canceled, the pilot training was approved for the area director at a cost of several thousand dollars.

On the video equipment purchases, I have asked the Justice Department to advise the committee by what legal authority the delivery was accepted prior to the purchase order and that a sole source purchase order was used rather than a competitive bid.

The committee continues conducting an in-depth examination of other questionable expenditures identified in that December 21 hearing. These expenditures concern video production, Northern Montana Hospital charges for Indian patients, and use of out-of-State anesthesiologists, requiring the payment of travel expenses, rather than someone local.

The committee has retained two auditors to conduct an in-depth review of the practices in these instances to determine if they are sensible and prudent. We will continue to receive testimony in regard to expenditures of Indian Health Service funds throughout the country.

I have for some time been curious as to the effective uses of the $600 million-plus annual appropriation for Indian Health Service. The goal of our investigation is to determine whether or not these funds are being used properly to actually deliver health care to the individual Indians or whether questionable practices are siphoning off the funds through improper expenditures.

Today, the committee is conducting the third in a series of Indian Health Service oversight hearings focusing on issues relating to the reauthorization of the Indian Health Care Improvement Act, Public Law 94–437. The committee will review this process by holding 2 days of hearings in Washington on April 21 and 22, at which time the administration witnesses will be heard from.

While this hearing is not directly related to the investigative hearing conducted in Billings last December, we want to make it clear that anyone who wishes to present testimony on the nature of a questionable practice or expenditure, may do so. That is part of our oversight function, and that is why we are here.

We will start with Lawrence Gilpin, treasurer of the Omaha Tribe of Nebraska, Macy, Nebr. Mr. Gilpin, please be seated.

STATEMENT OF LAWRENCE GILPIN, TREASURER, OMAHA TRIBE OF NEBRASKA, ACCOMPANIED BY NANCY HURROD, EXECUTIVE DIRECTOR OF HEALTH SERVICES

Mr. GILPIN. Senator, ladies and gentlemen. The Omaha Tribe of Nebraska, located on the Omaha Reservation, Thurston County, Macy, Nebr., wishes to address several issues. The Omaha Tribe of Nebraska operates under Public Law 93–638, a health facility with a 25-bed nursing home. We contract with Indian Health Service, Aberdeen area, but please be reminded that Aberdeen did not help us get operating moneys. The Omaha Tribe of Nebraska received appropriation directly from Congress who mandated our appropriation through IHS, Aberdeen area.

The issues we would like to address are:

No. 1, it appears we are not allowed to exercise our full authority under Public Law 93–638. It seems we are self-determined by IHS rules and regulations. Example: We are constantly reminded that we have to follow the rules and regulations set out by IHS and are at times referred to as an IHS service unit, yet we are not afforded the same privileges allowed the service units. An example of this is a service unit directors meeting going on this week, we were not even asked to attend. Why should we have to follow IHS rules and regulations? It appears to us that if we are following our contract and are doing what we set out to do, then we should not be hassled. Another example: We have to get prior approval before we can do anything for the center, health services, and so forth.

No. 2, equality of treatment. We are not treated equally as the other tribally run programs. Example: The Winnebago Tribe received approximately $500,000 in operating moneys from the other disciplines.

We did not receive anything over our appropriated amount. We are only asking to be treated equally.

No. 3, technical assistance. We have asked time and time again for technical assistance from the Aberdeen consultants for our staff. As a matter of fact, it was agreed upon at negotiations of a new contract in September 1979 for all the area consultants to be down on or before December 31, 1979. Only two made it down. Our staff did not understand a lot of the reporting forms that the IHS has to contend with and why it is mandatory for us to do this.

No. 4, information and involvement. The Omaha Tribe of Nebraska requests that we be more involved in the budgetary process for Indian health care since we are responsible for all the Omaha tribal members. We also request information pertaining to health sent at the same time it is received in Aberdeen. Many times we do not receive information until after the fact. Example: Meeting notices pertaining to health are not received in time for us to attend.

Recommended improvements for health: No. 1, mental health. IHS should have a center to address these needs. We are located in a rural area and do not have access to health professionals in this field. No. 2, Public Law 94–437, the Indian Health Care Improvement Act. It appears few tribes actually receive any moneys for this. If we did, then we would recommend reauthorization of this act.

Your attention is appreciated. Thank you.

Senator MELCHER. What particular IHS rules and regulations do you find not operable or not sensible?

Ms. HURROD. Sir, if I may answer that. I am the director of the health service in Macy, Nebr. Our health facility is operated under Public Law 93–638. We do contract with them. Yet, at the same time, they want us to follow all the Indian Health Service rules and regulations, which we feel is not appropriate to the center there.

Senator MELCHER. Doesn't the contract require that?

Ms. HURROD. In the original proposal that we wrote, we stipulated what we wanted to do, and the end result was Aberdeen—the contractors threw a bunch of things in there that they wanted us to follow.

Senator MELCHER. If you have some specific items in the contract that you are questioning; that is what we are asking.

Ms. HURROD. We have asked for things like technical assistance. As a matter of fact, we opened that center in June 1978. We requested technical assistance for all our consultants to come down and explain all these reporting forms, which they did not. And then in August, I requested, in writing, technical assistance again, and nothing happened. They did send down an itinerary of when they would be down, but nobody came down. And then again, at our last negotiation in 1979, it was stipulated in the contract that they would be down on or before December 31. Now, only two of them came down, and I feel that we are not receiving properly all the technical assistance that we should have.

Senator MELCHER. I notice this mental health recommendation, but is there anything else in regard to the technical assistance and mental health recommendation?

Ms. HURROD. Well, we did have some problems on—like quality of treatment in the center there. We get a line item appropriation directly from Congress. The Aberdeen area office feels like we get plenty of money, therefore we do not need any more moneys, but this is not

true. All the other disciplines, get moneys appropriated to them, and then they send it out to all of the other tribal programs. Yet, we do not get anything. We are supposed to exist on what we get by contract, which I feel is entirely unfair.

As a matter of fact, in this contract, I think they were going to give us $4,000 from the social services, but in the end, they pulled it back and said we did not need it. This is not true.

Senator MELCHER. Is the health facility only involved with the 25-bed nursing home?

Ms. HURROD. We have an outpatient clinic, a four-chair dental area. We have optometry. We run our own ambulance service, and we have social services. We do have a mental health technician.

Senator MELCHER. Do you have Indian Health Service doctors assigned there?

Ms. HURROD. No, sir.

Senator MELCHER. Do you hire your own?

Ms. HURROD. Yes, we hire our own.

Senator MELCHER. Do you hire your own dentists?

Ms. HURROD. Right.

Senator MELCHER. And you have no services contracted by yourself or your own ambulance?

Ms. HURROD. Our own people.

Senator MELCHER. You pay for it out of your own funds?

Ms. HURROD. Yes, sir.

Senator MELCHER. First of all, is this on the reservation?

Ms. HURROD. Yes, sir.

Senator MELCHER. How many members of the Omaha Tribe are there on the reservation?

Mr. GILPIN. Approximately 1,650.

Senator MELCHER. 1,650?

Mr. GILPIN. Yes, sir.

Senator MELCHER. Is Thurston the name of the town?

Mr. GILPIN. No, it is Thurston County.

Senator MELCHER. Macy is the name of the town?

Mr. GILPIN. Yes.

Senator MELCHER. Is it on the reservation?

Mr. GILPIN. Yes.

Senator MELCHER. Well, as far as we know, the contract health facility must follow the rules and regulations of IHS; isn't that correct?

Ms. HUNT. As far as I know, yes.

Senator MELCHER. We do not think they have any option on that. If you can identify particular rules and regulations that are not workable, we will be glad to work with you on that. Would you care to submit some examples to us?

Ms. HURROD. Yes. Another example is our 25-bed nursing home is generating—we are certified by the State, and as you know, the State has no jurisdiction on the reservation, but we asked to be certified to live by the rules and regulations of the State. We are generating third-party moneys, and yet we cannot spend them, because at one point in time, Indian Health Service would give us that money or turn it back to the State. We asked Mr. Emery Johnson for help and asked him to clarify this, and the last we heard was that we could spend that money any way we wanted to spend it, but Aberdeen is telling us we have to get prior approval.

Senator MELCHER. These are third-party funds?

Ms. HURROD. Yes. And right now, it is just sitting in a bank so we would like to get an answer on this. If we can spend it, we would like to spend it and upgrade some of the services that are needed there on the reservation. Otherwise—and the State keeps telling us, "That's your money."

Senator MELCHER. The State isn't claiming the money at all, is it?

Ms. HURROD. No, sir.

Senator MELCHER. It belongs to the center?

Ms. HURROD. Yes, sir.

Senator MELCHER. And you are getting conflicting advice? Dr. Johnson says, "It is your money," and, "Use it," and the area office says you can not. Well, we will find out about that. I think Dr. Johnson is correct on that.

Mr. RICHTMAN. I think so.

Senator MELCHER. We will certainly check it out for you.

Ms. HURROD. The last we heard, Mr. Johnson was going to get a legal opinion on this, but——

Senator MELCHER. We will make sure it is clarified immediately. Thank you very much.

Our next witness is Mr. Patrick Doss, assistant tribal health director, Crow Tribe, Crow Agency.

STATEMENT OF PATRICK DOSS, ASSISTANT TRIBAL HEALTH DIRECTOR, CROW TRIBE

Mr. Doss. On behalf of the Crow Tribe, I would like to take this opportunity to thank the committee for allowing testimony from a tribal perspective, both as consumers and in professional dealings with the Indian Health Service. I would like to be allowed to read the testimony for the record and then answer any questions the committee may have.

This testimony will represent the views of the Crow Tribe of Indians of Montana on five major issues. Those being: the intent of Public Law 94–437, the Indian Health Care Improvement Act; the need for emergency medical services to be a direct budget line item of Indian Health Service; the trust responsibility of Indian Health Service to the Crow Tribe; Indian Health Service accountability and management practices; and most importantly, the nonresponsiveness of the Billings area office of Indian Health Service to the health services division of the Crow tribal administration.

No. 1, Public Law 94–437. The Crow Tribe of Indians, being a firm believer in Indian self-determination, supports the full intent of Public Law 94–437, acknowledging the law as the most important legislation affecting Indian people since the passage of the Indian Self-Determination and Educational Assistance Act. The need for the Congress of the United States to support the law through appropriations funding is thoroughly documented and supported by the Crow Tribe of Indians through tribal adoption of the Crow Tribal Specific Health Plan listing five categories of unmet health needs. Those are: emergency medical services; alcoholism and substance abuse; provision of skilled nursing home; environmental health; and comprehensive health education. The Crow Tribe would only hope that Congress also views this legislation to be of paramount importance to the health status of Indian people throughout this great country.

No. 2, emergency medical services. At present, a comprehensive emergency medical services system is virtually nonexistent on the Crow Indian Reservation, a land base which exceeds 2 million acres of land with over 1,000 miles of highways and dirt roads. The Crow Tribe is presently developing a comprehensive EMS system which will require not only a deep commitment and participation on the part of Crow people, but also a thorough search for adequate funding to initiate the program.

On February 28 of this year, the Crow Tribe testified to both the House and Senate Appropriations Committees of the need for such a program. Initial startup costs are staggering with continuing yearly operating expenses estimated at approximately $200,000. However, the need and moral commitment to save the lives of Crow people totally outweigh the monetary expenditures. As is the case with other tribes, funding of an EMS program will result in a yearly fight-for-survival funding. The Crow Tribe therefore recommends that emergency medical services be realistically considered to be included as direct line budget item within the budget of Indian Health Service.

No. 3, trust responsibility. Historically and presently, the Crow Tribe of Indians has recognized Indian Health Service as a primary provider of health care to the Crow people. However, Indian Health Service considers itself a residual provider of health care. In assuming this posture as a residual provider, the Crow Tribe believes that the legal rights of Crow Indians and legal responsibilities of Indian Health Service to the Crow people could be severely undermined in the future.

The trust responsibility of Indian Health Service to the Crow Tribe indicates a need for clarification of the residual provider status of Indian Health Service to further safeguard the rights of the Crow people and insure that the legal responsibilities of Indian Health Service are adhered to.

No. 4, Indian Health Service accountability and management practices. Accountability on the part of Indian Health Service to the Crow Tribe is virtually nonexistent. The Crow Tribe has determined that Indian Health Service officials not only do not respond to inquiries regarding accountability but dictate all policy to the tribal government and Crow beneficiary. However, when it comes to the Crow Tribe being accountable to Indian Health Service for the management of its programs, the definition of the term is very clear.

The Crow Tribe has viewed Indian Health Service management practices as being a primary problem at the Crow Service Unit and Billings area office. Key positions within Indian Health Service are most often filled by individuals with very little formal education in health systems management. This can be substantiated by reviewing the educational backgrounds of not only the Billings area director of Indian Health Service, but also of the present program manager at Crow Agency Service Unit. There appears to be a mangement system that is, for the most part, crisis oriented with little or no planning components in place for the health care of Indian people.

In addition, the central management system of the Billings area office has grown tremendously during the past 10 years. In fact, Indian Health Service testified during the 1980 appropriations House hearings that the supportive administrative staff for the Billings area office numbered 70, while at the same time, the official Indian Health Service employee directory lists numbered 148. We are consequently

seeing a large growth of centrally located Indian Health Service employees which, in reality, should be the smallest working component of any well-managed business. At the same time, the service unit level could very well experience cutbacks in employees because of President Carter's emphasis on a balanced budget.

The Crow Tribe therefore believes that a mechanism should be established which would mandate that Indian Health Service be more accountable to the tribe by establishing guidelines for tribal participation in the budgetary process at the area and local levels, for tribal participation in policymaking decisions, and in program management practices. Further, the rapid growth in the Billings area office should be curtailed with a major emphasis on the local service unit level where the business of health care is practiced.

No. 5, nonresponsiveness of Indian Health Service to Crow tribal administration. The Crow Service Unit has been characterized area-wide as the most mismanaged service unit in Montana, not only by the Crow beneficiary, but also by Indian Health Service personnel. The problems which we as Crow people are faced with are numerous, ranging from incidents of patient-physician confrontations leading to the closure of the Indian Health Service hospital to outright racism on the part of Indian Health Service employees to the Crow beneficiary.

Because of the ramifications of these problems, the Crow Tribe created a tribal health services division composed of a tribal health board and tribal health department. Based on a total lack of communications between tribal members and Indian Health Service, a grievance procedure was instituted and plan of operations adopted by the Crow Tribe through resolution, the intent of the Crow Tribe being to open communications in an effort to prevent any future severance of health services. We are now faced with several situations that have signaled the Crow Tribe to the lack of responsiveness of the Billings area director, Indian Health Service, to the wishes of the Crow Tribe.

More specifically, in March of this year, a new program manager and administrative officer were hired by the office of the area director without the informed consent of tribal officials. This decision came after verbal promises were made by the area director to key personnel in the tribal administration affirming that the tribe would participate in the selections. Failure on the part of the office of the area director in living up to the verbal agreements indicates a breach of faith on the part of Indian Health Service in a most critical area.

Second, in full view of the need for emergency medical services on the Crow Reservation, the office of the area director openly indicated, again verbally, that the Crow Tribe would be receiving an ambulance for the Pryor area, one of seven or eight which Indian Health Service recently purchased for the Billings area. The tribe has since found out that the office of the area director concluded that there was no visible interest in emergency medical services on the part of the tribe and subsequently detailed the ambulance elsewhere in light of the fact that: No. 1, the Crow Tribe delegated three tribal CETA employees to Indian Health Service in August 1978 to become ambulance drivers, only to have them become maintenance workers for the hospital; No. 2, the Crow Tribal Specific Health Plan specifically states emergency medical services as the tribe's highest unmet need; No. 3, the present grant funding the tribal health department states directly that a feasibility study on emergency medical services be completed

and a proposal be submitted in September 1980; and No. 4, the fact that congressional testimony before both the House and Senate Appropriations Committees will reflect a request for emergency medical services funding as a high priority.

Finally, the Crow Tribal Health Department has numerous letters which have been totally ignored and unanswered by the office of the area director, indicating a premeditated barrier to the tribal health department growth, planning efforts, and the spirit of Indian self-determination.

In conclusion, the Crow Tribe still feels that a working relationship could be developed if Indian Health Service was responsive. The development of a tribal health department capable of assuming the role of Indian Health Service on the Crow Reservation is no simple task, a task which will prove impossible if Indian Health Service does not respond. However, the Crow Tribe believes tribal involvement in health care delivery is paramount in its reach toward self-determination.

Thank you for your attention and allowing this testimony to be part of the record.

I do have those letters which we sent to the area director and service unit director which we have had no response to, and I have further documentation as to the growth of the area office of Indian Health Service.

Senator MELCHER. We will accept those as part of the record and they will appear at the end of your testimony.

You are saying that the Indian Health Service area office has 70 employees here in Billings, and that is true, as is evidenced by the hearing record for fiscal 1980 appropriations, and they are listed by name. However, you go on to say that the official Indian Health Service employee directory numbered 148. Are you testifying that those listed totaling 148 are all part of the area office of Indian Health Service here in Billings?

Mr. Doss. The Billings Area Office Quick Reference List, August 1, 1979, is made available to all tribal health departments, and I have a copy of it here. When you add them up, it does come to 148, unless, of course, there was a misunderstanding on the part of Indian Health Service officials as to what the question was.

Senator MELCHER. We will check this out. We will make this part of the record and see whether there is a discrepancy in temporary and permanent employees. If the 70 refers to permanent, whereas 148 includes temporaries—but I think it is misleading to provide a list of 70 to the Appropriations Committee of the House of Representatives in substantiating the justification for appropriation if, indeed, the number is much greater than that.

Mr. Doss. Yes, sir. My thinking entirely.

Senator MELCHER. Well, we are glad to have that information. We are glad to have that because that is one of our concerns; people involved in area offices compared to how much money is actually spent for the individual Indian patients.

Thank you very much, Patrick.

Mr. Doss. You are welcome. I would like to give the Senator copies of these letters.

Senator MELCHER. Oh, yes. We are going to make those part of the record, too.

[The material follows. Testimony reasumes on p. 23.]

CROW TRIBE OF INDIANS, PROGRAM NARRATIVE, TITLE III, NAESP, AUGUST 1978

1. NEEDS AND OBJECTIVE

The Crow Indian Reservation encompasses approximately two and one-half million acres in South-eastern Montana. The total Tribal enrollment is approximately 6,000. The population is basically rural, with Crow Agency serving as the governmental and service delivery center for the entire reservation. The Indian Health Service operates a hospital facility in Crow Agency, but the following facts deserve attention;

(a) Due to a lack of trained individuals and adequate funds, the Indian Health Service provides a limited emergency vehicle service during normal working hours only. The vehicle is used basically as a means of transportation (driven by available IHS maintenance personnel) and not as a means of administering any medical aid in emergency situations.

(b) The Indian Health Service has entered into an agreement with an off-Reservation, non-Indian firm to provide emergency vehicle Service. The Vehicle is located 13 miles from the Crow Indian Hospital.

(c) The town of Pryor is seventy-three miles from Crow Agency, which precludes the possibility of providing any emergency service from Crow Agency to that area.

(d) The Crow Indian Hospital has limited resources, and severe cases must be transported to the hospital in Billings which is a 130 miles round trip from Crow Agency.

The objectives of this program are:

(a) To have trained six members of the Crow Tribe to operate emergency vehicles and to obtain certification to provide emergency medical services in cases of necessity.

(b) To institute a means of providing emergency vehicle services to the remote rural areas.

(c) To have created a business opportunity for the trainees so that they could assume the Indian Health Service contract for emergency vehicle operations.

2. BENEFITS

As has previously been stated, the present emergency vehicle service on the Crow Reservation is being provided on a limited basis, in a limited area by a non-Indian firm. The successful completion of this program will provide the following benefits:

(a) More responsible emergency vehicle operation on the Crow Reservation.

(b) An opportunity for permanent, unsubsidized employment opportunities for members of the Crow Tribe.

(c) Personnel trained in emergency medical service.

3. METHODS AND RECRUITMENT

A. *Recruitment.*—The Tribal CETA program and personnel office will be used to identify those most in need of training and possessing the greatest potential for success. The established procedures for advertising the position, i.e. local newspapers and postings in the post offices in each of the reservation districts will be utilized.

B. *Assessment of Participants.*—Participants will be judged according to their needs, potential for completing the training, and willingness to organize their own business upon completion of the training. Special consideration will be given to bilingual individuals, vietnam war veterans and persons receiving public assistance.

C. *Orientation.*—A one week orientation program will be provided so that the trainees will totally understand all facets of this training program. The orientation will take at least a week so that each trainee will have the opportunity to individually discuss with the supervisors the concept of the program, and also provide them the opportunity to collectively discuss the thrust of the program and redirect it if necessary so that it meets their specific needs. A complete orientation package will be developed within thirty (30) days after the receipt of notification of the grant award.

D. *Counseling.*—Counseling for job training will be provided by the CETA staff and field representatives of the Montana State Employment Service.

E. *Payment of Training.*—Payment to the trainees will be made under the established regulations of the Crow Tribal CETA Program.

F. *On-the-job Training.*—On-the-job-training will be provided by the Indian Health Service. As was stated previously, the IHS presently has the emergency vehicles that will be used for actual on the job training. Also the trainees who will be working with those emergency vehicle services that presently service those areas.

G. *Job Development.*—The emergency vehicle service for the Crow Reservation is provided by a non-Indian residing off the reservation. As part of this program the trainees will receive guidance and training from the tribal Contract Officer and VISTA attorney in contract negotiations and compliance so that after successfully completing the training they can assume the IHS contract under the Indian Self-Determination Act and/or the Buy Indian Act. The Small Business Administration personnel from the BIA's Indian Business Development loan program will be brought in to help the trainees capitalize the new business venture.

H. *Job Placement.*—If contracting with the Indian Health Service proves to be a futile effort, steps will be taken to provide that service through a tribal contract. Preference will be given to those individuals who have successfully completed the training.

I. *Supportive Service.*—Health Service will be provided at no expense to the enrollees by the Indian Health Service. Day Care, Head Start and family planning services will be provided by ongoing Tribal programs.

J. *Other Manpower Activities.*—The Tribal CETA program will oversee the administration of the program. Since the individuals selected for this project will be trained for the specific purposes of assuming the IHS emergency vehicles contract, the Service Unit Director will be invited to observe and participate in the training so that steps can be taken before the training process is over to negotiate a final contract.

This program has been designed to utilize the local skills and expertise and minimize costs while maximizing benefits to the trainees. Thus, the supervisors will be drawn from the present staff and the program will be administered by the CETA staff.

BUDGET, TITLE III, NAESP

Emergency Vehicle

Administration cost: Training materials	$3,090
Trainee cost:	
Ambulance drivers (2,600 hrs/wk × $3 = 7,800.00 × 3 units)	23,400
Fringe benefits (23,400.00 × 15 pct)	3,510
Total	26,910
Total administration and trainee cost	30,000

CROW TRIBAL HEALTH BOARD
CROW AGENCY, MONTANA 59022

Our Reference: THD

October 4, 1979

James R. Smith
Area Director
Billings Area IHS
P. O. Box 2143
Billings, MT 59103

Dear Mr. Smith:

I am writing this letter to the present available services provided here at the Crow Service Unit. I will be addressing myself in direct reference to the current transportation service made available to the consumers.

The present transportation service is far from being adequate. The van vehicle could be replaced for a more adequate ambulance type transportation service. The ambulance would be better equipped to offer quality emergency care and transportation of the sick and injured on or near the Crow Reservation. The Big Horn County Ambulance contract is not the solution to our problem. We are second class consumers with this current arrangement. You may be able to save dollars, but not lives with this current contract. You have failed to take into consideration the vastness of our reservation and its population.

We need an ambulance that is adequately equipped to provide quality emergency transportation. The main goal of the Health Board is to be able to provide such a transportation service for the sick and injured on or near the Crow Reservation.

We are requesting your support and assistance to obtain an ambulance for the Crow Indian Hospital. We would greatly appreciate your efforts and time to see that our request is adhered, too.

In conclusion, we would appreciate some type of feedback for this particularly important request.

Sincerely,

Thelma Birdinground

Thelma Birdinground,
Health Board Chairman

cc: Forest Horn, Chairman
Crow Tribal Council
Crow Agency, Montana 59022

Service Unit Director
PHS Indian Hospital
Crow Agency, Montana 59022

CROW TRIBAL HEALTH BOARD
CROW AGENCY, MONTANA 59022

January 21, 1980

TO : Thelma Birdinground, Chairperson, Health Board

FROM : Marshall M. Left Hand, Tribal Health Director

SUBJECT: Hospital Administrative Services Vacancy

We scheduled a meeting with IHS Area Director, J.R. Smith at 10:00 a.m. We did not start the meeting until 1:30 p.m. in the afternoon. Those present at the meeting were the Health Board Chairperson, MIP Executive Director, MIP Assistant Director, Mr. Smith, and myself.

Mr. Smith discussed with the group about the past administrative activities and practices. He feels the present Program Manager does not have the administrative abilities to carry out the functions and program operations at the hospital. He stated that an individual with good management skills can eliminate most of the problems at the hospital.

Mr. Smith stated the vacancy announcement was made public in November 1979, and closed in December 1979. Three Indian applicants were considered for this position, but one applicant was considered qualified. He did not specify any particular reason why the other two candidates were considered non-qualified.

Mr. Smith strongly recommended the acting Program Manager for the Rocky Boy hospital. He gave us a brief employment background experience of Mr. Gilham. He did not go into Mr. Gilham's educational background. Mr. Smith was very confident that Mr. Gilham would be the individual to handle the duties and responsibilities at the Crow Service Unit.

Mr. Smith stated that he would schedule an interview session with the same group at a later date. He stated, that we could question Mr. Gilham as to how he would go about in handling the staff and operational problems at the hospital. He stated, if, we do not feel he is the ideal candidate they could readvertise for the position. But, if, we feel he is the candidate we could go ahead and accept him for this particular position. We were pleased with this mutual agreement because the Crow Tribe has never been involved in the selection of the Program Manager. Mr. Smith stated he would notify the MIP Executive Director as to when he would schedule the next meeting for the interview session.

HEALTH BOARD MINUTES

Health Board Meeting
February 13th, 1980
Health Board Office

Members Present
Thelma Birdinground, Chr.
Darlene Morning
Mary A. Shane
Quentin Big Medicine
Other Individuals Present
Marshall M. Left Hand
Wm. Patrick Doss
Sarah Goes Ahead

Minutes
The meeting was called to order by Chairperson Birdinground at 11:27 a.m. Chairperson Birdingroun requested the minutes for the February 8th meeting be read. Chairperson Birdinground called for correction to the minutes. They read as follows:

1. Quentin Big Medicine state that he had been appointed instead of volunteered to attend the workshop in Des Moines, Iowa.

Quentin Big Medicine moved that the minutes be approved as corrected and filed with the secretary. Darlene Morning seconded. Motion carried.

The purpose of the meeting was to meet with the Area Director from Billings, to further discuss the position of the Service Unit Director for the Crow Hospital. But since he didn't show up, the meeting still went on with the Health Director, Program Planner, and board members present. Chairperson Birdinground stated that a Billings employee from IHS is willingly to come down and help for 6 months to 1 year as a Service Unit Director. The Program Planner mentioned that something should be arranged on paper by Health Board for a 6 month advertisement for anyone who is put in as Service Unit Director and to present it to the Area Director.

The board agreed that a letter be made to PHS Area Office in Billings concerning any business they have with the tribe or IHS. That all IHS personnel visiting the Crow Indian Reservation on business relating directly or indirectly to Health programs to notify the Tribal Health Director. He should be noted the purpose of the visitation, time, and meeting place at least one week in advance.

Meeting with Industrial Development Committee
One of the board member gave a report on the meeting he attended at the PHS Crow Hospital with the Industrial Development Committee. He stated that the purpose of the meeting was on the Lodge Grass Health Clinic and where about it should be located. He mentioned that they suggested the area by the Arts and Craft building was a good location. However, the board didn't agree to this and suggested to write a letter to the Service Unit Director that the Health Board is sanctioned by the tribe for the plan of the Lodge Grass Health Clinic.

Adjournment
Quentin Big Medicine made a motion to adjourn meeting. Darlene Morning seconded Meeting was adjourned at 12:36 p.m.

Respectfully submitted,

Sarah L. Goes Ahead

Sarah Goes Ahead,
Secretary

65-491 O - 80 - 2

February 19, 1980

Mr. James Abeita
Community Development Specialist
BIA Area Office

Dear Mr. Abeita:

Please send an updated overview of P.L. 93-638 Grant appropriation for the Billings Area for 1979-1980 - obligated and unobligated funding; Community Development funding (obligated and unobligated); Tribal leader funding (obligated and unobligated); Tribal Training and Technical Assistance Funding (obligated and unobligated).

Please be advised that this information is critical for future planning. Also, please send a copy of our current Community Development contract.

Thank you,

Marshall Left Hand,
Director, Tribal Health

February 22, 1980

Carl Pence
Service Unit Director
Crow Agency, Montana 59022

Dear Mr. Pence:

Please make the following information available at the earliest possible date.

Position Statements; Job Descriptions;
Scope of Work; Standards of Performance;
For all of the listed positions:

- Community Health Director
- Environmental Health Service Engineer
- Sanitation Facility Construction Division
  1. Engineer Equipment Operator
  2. Equipment Operator
  3. Skilled Laborer
  4. Unskilled Laborer
- Health Educator
- Public Health Nurse
- Family Services Psychologist
- " " Social Worker
- " " " Associate
- Family Services Secretary
- Nurse Practioner
- Pryor Clinic Administrator
- Housekeeping - all one types

Thank you for the information.

Sincerely,

Marshall M. Left Hand

Marshall M. Left Hand,
Director, Tribal Health

March 6, 1969

Mr. Alan Gilham
Service Unit Director
Crow Agency, Montana 59022

Dear Mr. Gilham:

Enclosed is a copy of a request for information regarding the planning aspects of the Crow Tribal Health Board. Could you please see to it that this information is made available at the earliest possible date. Thank you for your prompt consideration.

Sincerely,

Marshall H. Left Hand,
Tribal Health Director

Enclosure

March 10, 1980

James E. Smith
Area Director
Billings Area IHS
P. O. Box 4143
Billings, MT 59103

Dear Mr. Smith:

On October 4, 1979, a letter was sent to your office (letter enclosed) requesting the need for an Ambulance to be located at the Crow Agency IHS Hospital. It is my understanding that an Ambulance was purchased by IHS specifically for the Crow Indian Reservation, however, the Ambulance was never delivered to the Crow Agency Hospital. I am concerned that the Crow Tribal Health Board and my office never received a reply to the letter dated October 4, 1979, and most importantly that the Crow Agency IHS Hospital never received the Ambulance.

The need for a more comprehensive IHS system has been addressed by the Crow Tribal Specific Health Plan as a top priority based on a Reservation wide survey of the Crow people.

I am requesting clarification on this important matter as soon as possible.

Most Sincerely,

Robert Yellowtail, Chairman
Crow Tribal Council

Enclosure

CROW TRIBAL COUNCIL

March 18, 1980
Office of the Chairman
Crow Agency, Montana 59022

Crow Country

FOREST HORN, Chairman
ANDREW BIRDINGROUND, Vice Chairman
THEODORE (Ted) HOGAN, Secretary
RONALD LITTLE LIGHT, Vice Secretary
PHONE: Area Code (406) 638-2993 - 2942

MEMORANDUM

TO : Tribal Health Services Department

FROM : Forest Horn, Chairman

SUBJECT: Testimony Authorization for Oversight Hearing on Indian Health Service; Select Committee on Indian Affairs

The Tribal Health Services Department is hereby authorized to testify before the Senate Select Committee on Indian Affairs in behalf of the Crow Tribe, on March 28, 1980 at 1:00 p.m. in the City Hall Council Chambers, Billings, Montana.

Sincerely yours,

Forest Horn, Chairman
Crow Tribal Council

cc: Robert Howe
Marshall M. Left Hand

DEPARTMENT OF THE INTERIOR AND RELATED AGENCIES APPROPRIATIONS FOR 1980

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES

NINETY-SIXTH CONGRESS

FIRST SESSION

SUBCOMMITTEE ON THE DEPARTMENT OF THE INTERIOR AND RELATED AGENCIES

SIDNEY R. YATES, Illinois, *Chairman*

GUNN McKAY, Utah
CLARENCE D. LONG, Maryland
ROBERT B. DUNCAN, Oregon
JOHN P. MURTHA, Pennsylvania
NORMAN D. DICKS, Washington
BO GINN, Georgia

JOSEPH M. McDADE, Pennsylvania
RALPH S. REGULA, Ohio
CLAIR W. BURGENER, California

FREDERICK G. HOUSMAN, RYRON S. NIELSON, and ROBERT S. KRIPOWICZ, *Staff Assistants*

PART 8

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Department of State	445
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Printed for the use of the Committee on Appropriations

Public Information Spec.	GS 09/3	14,982
Personnel Mgmt. Specialist	GS 11/5	21,831
Personnel Mgmt. Specialist	GS 12/2	19,905
Accounting Technician	GS 05/1	10,587
Personnel Mgmt. Spec.	GS 11/1	19,263
Freight Rate Specialist	GS 07/5	15,184
Safety Offcr., Disster Coord.	GC 06/0	33,806
Accounting Technician	GS 05/8	12,937
Procurement Agent	GS 10/4	20,432
Voucher Examiner	GS 07/8	16,851
Personnel Clerk (Typing)	GS 04/1	10,330
Accounting Officer	GS 12/6	26,937
Supply Clerk Typing	GS 06/7	12,208
Secretary (Typing)	GS 05/5	12,257
Voucher Examiner	GS 06/8	14,442
Clerk Typist	GS 03/4	10,319
Contract Administrator	GS 11/1	19,263
Position Class. Specialist	GS 11/10	25,041
Hospital Admin. Officer	GS 15/3	40,704
Facilities Mgmt. Clerk (Typing)	GS 05/4	11,907
Clerk Typist	GS 03/1	9,482
Financial Manager	GS 14/10	42,171
Secretary (EMT)	GS 05/10	14,707
Labor Mgmt. Emp. Relations Sp.	GS 11/9	24,399
Clerk Typist	GS 04/1	10,330
Clerk Typist	GS 03/1	9,482
General Services Officer	GS 14/4	35,685
Personnel Officer	GS 14/8	40,009
Secretary (Typing)	GS 06/3	13,272
Total Positions	86	

BILLINGS

Classification Clerk (Typing)	GS 05/3	11,207
Staffing Clerk	GS 04/1	9,391
Accounting Technician	GS 04/1	9,391
Accounting Technician	GS 04/1	9,391
Accounting Technician	GS 04/1	9,391
Data Transcriber	GS 03/1	8,366
Secretary Typing	GS 05/2	10,857
Voucher Examiner	GS 06/8	14,442
Laborer	WG 03/1	12,438
Procurement Clerk	GS 05/6	12,257
Office Assistant	GS 07/7	15,618
Statistical Clerk	GS 04/2	9,704
Contract Hlth. Clerk (Typing)	GS 05/2	10,857
Supply Clerk	GS 05/3	11,907
General Supply Specialist	GS 09/5	18,044
Voucher Examiner	GS 05/3	11,207
Accounting Technician	GS 04/1	9,391
Voucher Exam. Supv.	GS 08/7	17,296
Office Equipment Operator	GS 03/1	8,366
Clerk Typist	GS 03/1	8,366
Accounting Technician	GS 04/1	9,391

Accounting Technician	GS 05/10	13,457
Supv. Operating Accountant	GS 11/1	19,263
Clerk Typist	GS 04/1	9,391
Position Classification Spec.	GS 09/1	15,930
Personnel Officer	GS 12/9	29,247
Land Assts. Maintenance Clerk	GS 05/1	10,587
Contract Specialist	GS 11/4	21,189
Payroll Clerk	GS 05/1	10,587
Supv. Program Analyst	GS 11/4	21,189
Employee Relations Clk. Typ.	GS 04/1	9,391
Contract Specialist	GS 11/2	19,905
General Clerk (Typing)	GS 05/4	11,537
Program Analysis	GS 13/5	31,113
Computer Operator	GS 04/1	9,391
Admin. Management Asst.	GS 05/5	11,907
Pers. Staffing Specialist	GS 11/1	19,263
Contract Specialist	GS 12/1	23,087
Voucher Examiner	GS 06/7	14,052
Accounting Technician	GS 04/1	9,391
Secretary Typing	GS 04/2	9,704
Supply Management Officer	GS 12/6	26,937
Supv. Personnel Staff. Spec.	GS 12/1	23,087
Financial Mgmt. Officer	GS 13/1	27,453
Admin. Services Officer	GS 13/7	32,943
Accounting Technician	GS 04/1	9,391
Secretary Typing	GS 04/1	9,391
Financial Mgmt. Asst.	GS 07/10	16,920
Purchasing Agent	GS 07/3	13,882
Accounts Maintenance Clerk	GS 03/1	8,366
Supv. Contract Specialist	GS 13/2	28,368
Personnel Assistant	GS 07/7	15,618
Director, Indian Health	GS 15/7	45,792
Accounting Technician	GS 04/1	9,391
Employee Development Clerk	GS 04/1	9,391
Data Transcriber	GS 03/7	10,040
Special Assistant	GS 13/4	30,198
Secretary	GS 07/4	14,316
Program Planning A	GS 07/6	15,184
Accounting Technician	GS 04/6	10,330
Data Transcriber	GS 03/1	8,366
Staffing Clerk	GS 04/7	11,269
Employee Development	GS 12/9	29,247
Accounts Maintenance Clerk	GS 03/1	8,366
Accounting Technician	GS 07/6	15,184
Accounting Technician	GS 08/9	14,832
Procurement Clerk	GS 04/2	9,704
Data Transcriber	GS 02/1	7,422
Personnel Staffing Spec.	GS 11/1	19,263
Budget Officer	GS 12/6	26,937
Total Positions	70	

NAVAJO

Position Class. Specialist	GS 09/1	13,930
Secretary (Typing)	GS 05/1	10,587
Realty Specialist	GS 09/5	18,044

20

UUC 24

Question: Do you provide any patient services out of area offices?

Answer: Patients are not treated in IHS area offices. However area offices are responsible for providing physician and other professional consultation to the service units. These consultations are usually provided through the Chief Medical Officer and other professional health personnel.

Question: What specific duties do your area office have? How many area offices?

Answer: There are eleven IHS Area and Program Offices. The eleven (11) IHS Area and Program Offices reflect the extent to which the Director, IHS has decentralized and redelegated the administration of the IHS Program. The Area Offices under their redelegations of authority are primarily responsible for:

1. determining policies and priorities within the framework of IHS policy in pursuit of the IHS mission;

2. delivering and assuring the delivery of high quality, comprehensive health services through Service Units within the Area;

3. providing coordination or assuring the coordination of the Indian Health Service activities and resources internally and externally with those of other governmental and non-governmental programs;

4. participating in the development and demonstration of alternative means and techniques of health services management and delivery to provide Indian tribes and other Indian community groups with optimal ways of participating in the Indian health programs; and

5. assuring the development of individual and tribal capacities to participate in the operation of the Indian Health Service.

Question: When was the last time you reviewed your organizational structure to determine if that was the most effective way of providing service?

Answer: The IHS Area or Program Offices for California, Alaska, Albuquerque Billings, and Portland have been reorganized within the last three years. Bemidji and USET have currently proposed a reorganization leaving only four (4) Area Offices that have not proposed a reorganization structure in the last three years. Consequently, organization structure is constantly reviewed to determine the most effective means of providing services.

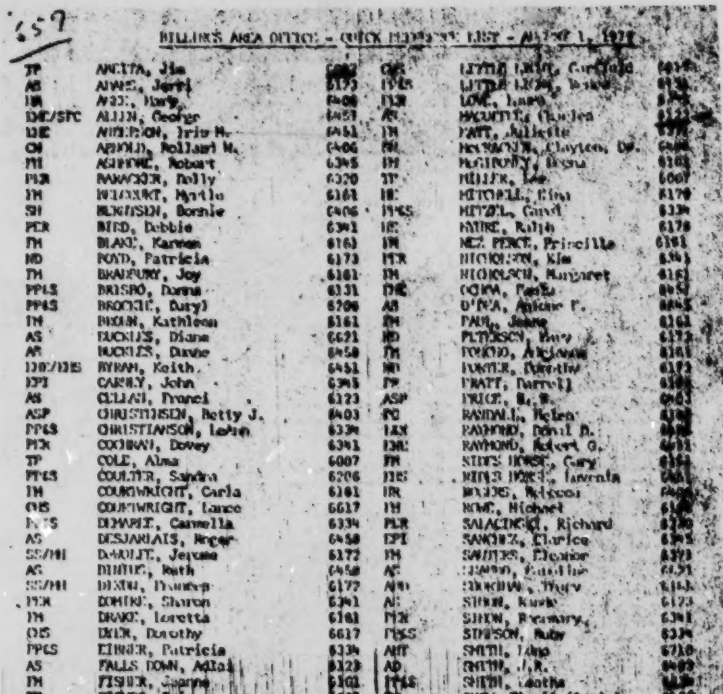
Question: Do you think the cost of your area offices are reasonable?

Answer: Yes. The centralization of program management and support activities in the area offices has resulted in a substantial savings as compared to providing such services in each individual installation.

Question. Provide a list of your personnel for Area Offices as requested for Program Management.

Answer. List of personnel on duty as of March 31, 1979 for Area Office Services is as follows:

TITLE	AREA OFFICE GRADE	SALARY
Procurement Agent	GS 09/3	$16,989
Accounting Technician	GS 05/4	11,557
Voucher Examiner	GS 06/10	15,222
Accounting Technician	GS 05/4	11,557
Staffing Clerk	GS 05/1	10,507
Clerk	GS 06/8	14,442
Laborer	WG 02/2	12,376
Supv. Accounting Technician	GS 09/4	17,513
Deputy Area Director	GC 06/0	22,903
Contract Specialist	GS 09/7	19,106
Secretary (Steno)	GS 05/1	10,507
Payroll Supervisor	GS 07/8	16,052
Administrative Clerk	GS 06/8	14,442
Secretary (Steno)	GS 05/4	11,557
Personnel Staffing Spec.	GS 11/2	19,903
Voucher Examiner	GS 06/5	13,372
Voucher Examiner (Typing)	GS 05/1	10,507
Hospital Admin. Officer	GS 13/7	45,792
Voucher Examiner	GS 04/1	9,391
Engineering Technician	GS 11/5	21,831
Secretary (Steno)	GS 06/8	14,442
Accounting Technician	GS 07/4	14,316
Voucher Examiner	GS 06/7	14,057
Accounting Technician	GS 05/3	11,207
Staff Assistant	GS 08/9	19,234
General Engineer	GS 13/8	33,836
Class. and Wage Specialist	GS 12/1	23,007
Asst. Financial Manager	GS 13/6	38,838
Statistical Assistant	GS 07/1	13,914
General Supply Spec.	GS 09/7	19,106
Public Health Analyst	GS 13/2	29,340
Dir. Aberdeen Area	GC 06/0	30,336
Comm. Hlth. Rep. Coordinator	GS 11/1	19,263
Payroll Clerk	GS 03/1	8,344
Voucher Examiner (Typing)	GS 05/2	10,857
General Services Officer	GS 14/2	33,323
Personnel Mgmt. Specialist	GS 07/2	13,448
Program Analyst	GS 11/1	19,263
Secretary (Typing)	GS 04/1	9,391
Peripheral Equip. Operator	GS 03/1	8,344
General Engineer	GS 14/8	40,009
Personnel Officer	GS 13/9	34,773
Nutrition and Dietetics Offer.	GS 13/7	32,943



BILLINGS AREA OFFICE - QUICK REFERENCE LIST - AUGUST 1, 1978

TP	ANETTA, Jim	6007	CHS	LITTLE LIGHT, Garfield	6414
AS	AUNE, Jerri	6173	PHS	LITTLE LIGHT, Irene	6138
IR	AUST, Mary	6408	PIR	LOVE, Laura	6304
DE/SFC	ALLEN, George	6457	AS	MACARTHY, Charles	6121
DE	ANDERSON, Iris M.	6451	IH	MATT, Juliette	6178
CH	ARNOLD, Hallard M.	6406	MH	MCCRACKEN, Clayton, Dr.	6406
MI	ASPHAUL, Robert	6345	EH	MCGRORTY, Irene	6161
PIR	BAHADOR, Polly	6020	TP	MILLER, Lee	6007
IH	BELGARDE, Myrtle	6161	HC	MITCHELL, Elva	6179
SH	BENSON, Bernie	6406	PHS	MITZEL, Carol	6134
PER	BIRD, Debbie	6341	HC	MOORE, Ralph	6178
IH	BLAKE, Karmen	6161	IH	MCT PENCE, Priscilla	6161
MD	BOYD, Patricia	6173	PIR	NICHOLSON, Kim	6345
IH	BRADBURY, Joy	6161	IH	NICHOLSON, Margaret	6161
PPHS	BRISBO, Norma	6131	DHC	OCHOA, Paula	6405
PPHS	BROOKIE, Daryl	6206	AS	O'DEA, Arlene F.	6405
IH	BROWN, Kathleen	6161	EH	PAUL, Joann	6161
AS	BUCKLES, Diane	6621	MD	PETERSON, Mary	6173
AS	BUCKLES, Duane	6458	IH	POWDER, Arlene	6161
IDE/DIS	BYRAM, Keith	6451	MD	PORTER, Dorothy	6173
EPI	CARNEY, John	6345	PP	PRATT, Darrell	6206
AS	CELLAI, Francl	6123	ASP	PRICE, R. W.	6403
ASP	CHRISTENSEN, Betty J.	6403	PC	RANDALL, Helen	6206
PPHS	CHRISTIANSON, Lelen	6334	IAX	RADFORD, Donal R.	6406
PER	COCHRAN, Dovey	6341	IRC	RAYMOND, Robert G.	6411
TP	COLE, Alma	6007	PH	SIDES HORSE, Gary	6161
PPHS	COULTER, Sandra	6206	PHS	SIMMS HORSE, Lavenia	6161
IH	COURNOYER, Carla	6161	IR	SMALLEY, Rebecca	6406
CHS	COURTWRIGHT, Lance	6617	IH	SMC, Michael	6161
PHS	DEWART, Camella	6334	PLR	SALACINSKI, Richard	6206
AS	DESJARLAIS, Roger	6458	EPI	SANCHEZ, Clarice	6345
SS/MH	DARDLET, Jerome	6172	IH	SAMUELS, Eleanor	6173
AS	DIMITS, Ruth	6458	AS	SHARP, Caroline	6451
SS/MH	DIXON, Frances	6172	AMH	SHOEBOW, Mary	6161
PER	DOMINE, Sharon	6341	AS	SIMON, Kevin	6123
IH	DRAKE, Loretta	6161	PER	SIMON, Rosemary	6341
CHS	DYER, Dorothy	6617	PHS	SIMPSON, Ruby	6334
PPHS	EINER, Patricia	6334	AMF	SMITH, Ida	6710
AS	FALLS DOWN, Adlai	6123	AD	SMITH, J.R.	6409
IH	FISHER, Joanne	6161	PHS	SMITH, Martha	6334
TP	FISHER, Rela	6007	IH	SNOW, Ellwell (Ossie)	6168
IOD	FITZPATRICK, Marva	6171	PHS	SPENCER, Cheri	6334
PER	FOOTE, Clifford	6406	AS	STEWART, Elsie	6458
DE	GILPIN, Joy	6451	CDI	STIL, Loretta	6178
DE	GOES AHEAD, Rhea	6451	PLR	TAYLOR, Dorothy	6206
PER	GOOD LUCK, Marella	6169	SHS	THOMAS, Larry S.	6406
IH	GRANT, Mary (Susie)	6161	DE	TOBINS, Betty	6345
IH	GRAUHAM, John	6161	SS/MH	TOMER, Maryann	6172
IOD	GURNEY, Dona M.	6659	AD/SSS	TOWN, Jane	6409
IH	HARRY, Marlene	6161	IOD	TRUMPON, Robert	6178
IH	HARRY, Robert	6161	PHS	TURNER, Margaret	6206
PER	HEINOL, Tom	6320	CHS	TURNS PLENTY, Alice	6617
PPHS	HIGGINS, Debra	6334	PLR	TURNS PLENTY, Coralee	6206
PER	HINE, Glen	6341	PER	VAN TINE, Russell	6320
AUD	HLADEK, Glen	6616	IH	WALKING BEAR, Allie	6161
AS	HOFFAN, Ellen	6123	PHS	WALL, Mary	6123
DE/SFC	JENSEN, Douglas	6451	AM	WALLETTE, Robert	6458
DE/DIS	JOHNSON, Dale J.	6451	DHC/AOH	WARRINER, William J.	6406
DE	JOHNSON, Marlyn, Dr.	6345	IH	WHITE, Evelyn	6161
AUD	JOHNSON, Ronald	6616	PH	WHITE, Lenora	6161
PPHS	KELLOGG, Carol	6206	AUD	WELCH, Shanon	6168
DE/DIS	KENNY, Raymond	6451	DHC/AOH	WERRE, Mark	6406
DE	KILLS PRETTY ENEMY, Dale	6451	PER	WETZEL, Nora	6341
PR	KILLS PRETTY ENEMY, Jolene	6168	AS	WHITE CLAY, Alice	6123
AS	KITTSON, Kathy	6458	AS	WHITMAN, Chunnie	6458
PER	KITTSON, Myrna	6341	CH/LEX	WHITMAN, Valeen	6406
PER	KOEGLER, Carole	6320	DHC/AOH	WILLIAMS, Ken	6406
IOD	LaFRANCOISE, Robert	6171	IOD	WINDY BOY, Ina L.	6659
PPHS	LAMBREAU, Darlene	6131	MH	WINDY BOY, Marva	6173
AS	LARSON, William	6123	PER	WOELDORF, Gladys	6341
AS	LAVENDUSK, Patricia	6445	IH	WRIGHT, Robert E.	6161
CHN	LITZ, Eileen	6178	IH	YOUNG, Leslie	6161
AUD	LEWIS, Charles	6165	CHS	ZIMMER, Jerome A.	6617
PPHS	LIGHT, Harvey	6206			
SS/MH	LITTLE LIGHT, Audrey	6172	AREA INDIAN HEALTH BOARD		656-2700

Senator MELCHER. Eva Beaks, tribal council, Three Affiliated Tribes of North Dakota, New Town, N. Dak.

Please proceed, Eva.

Ms. BEAKS. Your Honor, we have a tribal planner here who is going to do the reading of our testimony.

Senator MELCHER. You're Tom Abe?

STATEMENT OF TOM ABE, TRIBAL HEALTH PLANNER, ACCOMPANIED BY EVA BEAKS, TRIBAL COUNCIL, THREE AFFILIATED TRIBES OF NORTH DAKOTA

Mr. ABE. Tom Abe, tribal health planner. I would like to read the letter from the tribal chairman and then, the testimony.

We have a very different service area. We have a large earth dam in the center of the reservation which divides our Indian community into six isolated areas, and we also depend heavily on contract health care because of the lack of adequate staffing of our authorized Indian health care positions. This is not really taking into account the tribal specific health plans.

I will begin now with a letter from our tribal chairman.

Eva Beaks, by the way, is the tribal council human resource chairman and is in charge of all the health issues on the reservation. I operate out of the department of the tribal health planning component.

This letter is from Austin Gillette, the tribal chairman and reads as follows:

DEAR SENATOR MELCHER: Enclosed are copies of material to be included for the Senate select committee hearings at Billings concerning the remaining 4 years of Indian Health Service unmet need.

Elements of our testimony discuss the main reason why Indian Health Service has not been able to design an adequate health care system. Simply summarized, the Federal Government does fund IHS according to its own plans, guidelines. Medical assistance and medicare are examples of entitlement moneys which do not limit services by a periodic underfunded budget.

Indian Health Service policies concerning contract health care funds have continued to be the most sensitive area of health care.

Our tribal members have repeatedly expressed their desire to have the freedom of choice of their hospital. Indian Health Service, however, has a highly limiting referral system. This referral system mandated by IHS contract health care regulations seriously interrupts urgent health care and has resulted in many tribal council grievances.

In one such case, an elderly Indian veteran refused a Veterans Administration referral which probably contributed to untimely death. Another case is of a middle-aged Indian woman who received inadequate medical therapy which resulted in massive hemorrhaging before she was put on proper medication at a more specialized hospital. This person also died after being disabled from treatment at the first referral. As a result of this contract care policy, people and their families who are experiencing these problems are losing faith in Indian Health Service.

Open-ended funding mechanisms such as Veterans Administration should be implemented to resolve the continuous crisis situation under which contract health care funds are administered.

The Three Affiliated Tribes, realizing the shortage of qualified Indian health care professionals, also strongly supports the INMED program's efforts in its recently submitted congressional testimony under title I of Public Law 94-437.

We hope you will take seriously the recommendations included in this testimony and keep in mind that most of the personnel and contract moneys were calculated from congressionally approved methods.

We hope that in the future, we will be able to work with Indian Health Service in a manner which maximizes mutual participation in designing an adequate health care system for the Three Affiliated Tribes. This planning will be far more cost effective and reasonable than the present crisis-oriented system.

Sincerely,

AUSTIN H. GILLETTE,
Tribal Chairman.

Senator MELCHER. Thank you.

Mr. ABE. I still have the testimony to present.

Public Law 94–437 was an attempt by Congress and Public Law 94–437 proponents to fund IHS according to congressionally approved methods. An example of this is the resource allocation criteria for manpower and contract health funds. The intent of Public Law 94–437 was to give Congress a mechanism, an authorization bill, to allow for later appropriation of the greatly underfunded IHS need. To date, the underfunded IHS budget still exists, manpower is still inadequate, and contract funds are critically low. Public Law 94–437 has done very little nationally in terms of appropriation, and its intent to adequately appropriate the unmet need has not been significant.

Guaranteed funding which can meet the demand of the Indian Health Service population are those mechanisms similar to medicaid and medicare, giving you an example of medical assistance as being a type of funding mechanism which is more sane than the present IHS budget.

Medical assistance, title XIX, or medicaid, has been "authorized to be appropriated for each fiscal year a sum sufficient to carry out the purpose of the health care delivery to recipients," and this is taken from 42 U.S.C.A. 1396. Medical assistance then results in a method of distributing services which vary with the actual demands of health consumer and are not limited by a fixed local budget.

Indian Health Service has a congressionally limited budget which has been underappropriated by congressional markup committee cutbacks. The result is a crisis oriented health care delivery system, erratically funded, partially staffed, without the flexibility to respond to the varying demands of the health service population. Indian Health Service, however, is the major health care provider for most Indians on reservations, so its role is crucial. Indian Health Service is dependent on Public Law 94–437 for credibility so that it can improve and direct the contract health services for Indians. The number of persons not seen by a doctor, the unavailability of emergency personnel, the great lack of specialty care, the lack of adequate followup care are the consequences of previous limited congressional appropriations.

Medical assistance, which funds according to the need and the number of eligible recipients upon demand, which allows for the consumer to choose his or her health care provider, and which is not limited by an underappropriated budget, contains elements which should be applied to our most accessible health care delivery system in Indian Health Service.

Medicare is another example of funding which guarantees the health consumer services by implementing the Federal hospital insurance trust fund. This is 42 U.S.C. 1395(i). Medicare then provides medical insurance for certain valid limited services. The idea is that there should be a guarantee for the planned health services of any health care delivery system.

Health planning is a part of this guaranteed benefit package for services to specific Indian population. According to Public Law 94–437,

our tribal specific health plan was created, but without its corresponding funding, it will lack meaning as will Public Law 94–437. Congress should not sacrifice their originally approved methods of calculating health care needs at the markup committees. By not guaranteeing funds for the health consumer, health planning loses its relevance, and if there is no planning, there is no reasonable method of health care delivery. All tribes should be able to partake in this type of realistic plan for a health care delivery system which includes a funding guarantee for a corresponding benefit package.

It is important to note that Indian Health Service does not have adequate backup of congressional funding for its designated Indian service population which makes their planning system unrealistic.

Indian Health Service policies. Policies of Indian Health Service which result from a limited budget create a crisis atmosphere for both the health care provider and consumer. The present Indian Health Service budget for most reservations in the Aberdeen area is one-half to two-thirds deficient.

The Three Affiliated Tribes in Western North Dakota experienced a 68.4-percent deficiency in funding according to Indian Health Service calculations in 1979.

General action. Point one. Policies which need revision to make an adequate contract care referral system should allow the health consumer a freedom of choice of vendor with the corresponding appropriate funding mechanism which does not restrict the quality of care of his or her choice. This already is the case for medical assistance recipients.

The authorization of contract health care to recipients of federally recognized tribes and their spouses should not be restricted by mandatory approval of their corresponding service unit. This is a highly limiting policy which prevents, in many instances, critically needed contract health care to persons who visit or reside in other reservations or persons who reside in any nonreservation setting. The Snyder Act, which indicates a national health care trust responsibility, did not set limitations on health care delivery for the remaining small populations of Native Americans.

Point two. The Three Affiliated Tribes request a waiver of regulations to implement a pilot project of medicare premium payment by Indian Health Service. Although medicare has been available to the Indian elderly, few participate in the program because of cost. With limited income and demands on their income, it is difficult to pay quarterly premiums. The elderly then become victims of the Indian Health Service contract services when funds are depleted each spring, and their illnesses must be timed to coincide with Indian Health Service funding. Although emergency cases may be cared for, the time lapse becomes critical. With the passage of recent legislation, it is now possible for Indian Health Service to receive medicare payments; however, this will be limited because of the few elderly who take part in medicare. The tribal business council has gone on record to request payment of the premiums for medicare by Indian Health Service, and attached is a resolution to that effect, Resolution No. 79–37, for the elderly on the Fort Berthold Reservation. This payment would provide for better health care for the elderly, making possible a choice of physician and hospital care and a savings in contract health care payments.

There are approximately 134 members of the Three Affiliated Tribes over age 65. This was done in 1978, I believe. The premiums for medicare are approximately $50 per quarter, so this would amount to about $26,800 per year for the payment of these premiums. A long illness of several elderly would exceed the medicare premium payment for the total number of enrolled members over age 65. This dollar amount was proposed in 1979 but should be adjusted for the 1981 to 1984 Indian Health Service budget.

Specific action. Full funding of our tribal specific health plan for the 1984 unmet need. Realizing that accelerated health care costs are a major national problem, health planning can help to develop a more cost-effective system of health care. The Three Affiliated Tribes Tribal Specific Health Plans are the first step in rational health planning.

Then, we list the components of the number of positions which are a part of our tribal specific health plan. The unmet need, calculated according to congressional standards, was 51.4 positions by 1984, and contract health service moneys totaled $3,188,456.40. This also was calculated with the congressionally approved methods or resource allocation criteria. Coupling this with a non-RAC program, such as alcoholism and emergency care, which is also included in the tribal specific health plan, is a total unmet need by 1984 of $5,303,481.28.

The Three Affiliated Tribes' loss of a land base of more than 12 times the size of present reservation boundaries in the 1800's and the flooding of the home sites of 90 percent of the population through eminent domain with the loss of their hospital in the 1950's gives us a relative prospective of our relationship to the Federal Government so that a compensation for a sane and adequate health care delivery system is a sensitive area which should not be underappropriated. Already our previous generations have sacrificed for sake of the national interest through their loss of a great land and the corresponding economic control of this land. So we have justification of our status as one of this Nation's highest taxpayers.

Senator MELCHER. Do you have any difficulty collecting on medicare and medicaid? Do you have to wait on those payments?

Mr. ABE. Well, the State of North Dakota was slow in implementing the medicaid reimbursement policy. It has now comformed to that policy, and we are awaiting our input into determining the deficiencies of the service unit for which these funds, which are the Secretary of State's funds, 100-percent Federal moneys, will go to correct these deficiencies, and the tribe hopes to be a part of this process of identifying these deficiencies of our service, of which there are going to be quite a few, and it will not really compensate for all the need in personnel or contract moneys for that service unit. It will help.

Senator MELCHER. Do you have a problem with adequate funds for spouses, non-Indian spouses?

Mr. ABE. There are maybe a few problems, but I think there was proposed Federal regulations which indicated that—say it is a sex discrimination to not take care of the husband of an Indian spouse and to take care of the wife, so it is something that probably will be contested later. I know it has been in the Federal Register, but it has not been resolved yet. We have a lot of problems with contract care moneys on our reservation with the problem of staffing, and it is a sensitive

area, and the council has to deal with this time after time. There are many other problems because of geography and isolation of our six separate communities, but if we can get the unmet need, we can start from there. At least Indian Health Service will be getting money for what it had planned for in the first place.

Senator MELCHER. Do you get technical assistance in the Aberdeen area office?

Mr. ABE. We can request technical assistance from time to time, but our planning department and the council has a lot of work to complete in just maintaining the grants which funded our programs. This takes up a lot of our time. I think we could use more technical assistance and more coordination with their planning department.

Senator MELCHER. Do you have adequate time on notice for the grants?

Mr. ABE. I think we could use a little bit more time on the notice before the time that these grants are coming up. The guidelines are usually submitted very late, which gives us a crisis atmosphere to operate under. This is the case with many of the planners in the Aberdeen area. I am sure that they are under this pressure all the time so that they really can't go into detail and help on good quality needs assessment and health planning as I think we should be working on and finding cost-effective methods to deal with the health care.

Senator MELCHER. If I heard your testimony correctly, you are talking about IHS running out of funds in the spring.

Mr. ABE. Well, actually, they fund on a quarterly basis, for some reason, during that period, the funds are usually low.

Senator MELCHER. During the spring?

Mr. ABE. Yes, sir.

Senator MELCHER. How about in September? That is the end of the fiscal year.

Mr. ABE. Yes.

Senator MELCHER. Do you run out of funds then, too?

Ms. BEAKS. Yes, usually toward the end of the fiscal year.

Senator MELCHER. There have not been any emergencies that were not taken care of, have there?

Mr. ABE. Well, as was alluded to in the letter from the tribal chairman——

Senator MELCHER. I mean emergencies for lack of funds.

Mr. ABE. It's the lack of funds which causes an erratic type of referral system.

Senator MELCHER. I understand that, but I am just trying to see how bad it is. You do not have any instances where they say, "We're out of money," do you?

Mr. ABE. Yes, we have run out of money a couple of times.

Senator MELCHER. Completely?

Mr. ABE. Yes, completely. We have been in the red, and I have asked the service unit director—we have a great turnover of service unit directors. We have had about three or four this last year—what is done when you overspend your budget, and he said that—this one director I mentioned—he just gets a reprimand from the area office, which means there is no plan to implement more money when the need is great. Indians are referred to areas where the cost is least expensive,

like the Public Health Service Hospital, so they really do not have a freedom of choice in their health care. And when an emergency happens, nobody raises the issue, I guess, as it should be raised now.

Senator MELCHER. Thank you both, very much. The information you supplied will be made a part of the record at this point, including the resolution that was adopted, numbered 79–37.

[The material follows. Testimony resumes on p. 49.]

ATTACHMENT

BAC CALCULATED UNMET PERSONNEL NEED

(BAC Forms III - VII)

	AUTHORIZED FOR FY 1979	PERSONNEL UNMET NEED FOR FY 1984
CLINICAL CARE		
Primary care providers Note: One M.D. position is authorized but has been (TDY) vacant for several months	3.0	0.4
Registered Nurse	2.0	0.4
Licensed Practical Nurse	1.0	1.4
Nursing Assistant	0.5	1.5
X-ray Tech/Technologist	-	1.0
Lab Tech/Technoligist	1.0	-
Pharmicist	2.0	1.4
Pharmacy Auxiliary Staff	-	0.5
General Clerk	-	1.0
Medical Records Clerk	2.0	0.9
Housekeeping Staff	1.0	0.4
Maintenance Staff	1.0	1.7
Housekeeper/Driver/Maintenance Worker	-	1.4
Laboratory X-ray Worker	-	1.4
CLINICAL CARE TOTAL		13.4
ADMINISTRATION		
Administrative Officer/assistant	-	1.0
Secretary	-	1.0
Contract Health Services Staff	2.5	2.5
Communications Provider	-	1.0
Transportation Provider	-	2.0

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ATTACHMENT

RAC CALCULATED UNMET PERSONNEL NEED
PAGE 2

	AUTHORIZED FOR FY 1979	PERSONNEL UNMET NEED FOR FY 1984
ADMINISTRATION (cont.)		
Supply and Property Clerk	-	1.0
ADMINISTRATION TOTAL		8.5
BIOMEDICAL ENGINEERING		
Biomedical Engineering Technicial	0.0	0.3
BIOMEDICAL ENGR. TOTAL		0.3
QUALITY ASSURANCE		
Health Professional	0.0	1.0
Contractor	0.0	0.83
Clerk	0.0	0.63
QUALITY ASSURANCE TOTAL		2.5
DENTAL		
Dentist	1.0	1.0
Auxiliary Positions	1.0	3.0
DENTAL TOTAL		4.0
AUDIOLOGY		
Audiologist	0.0	0.33
Audiometric Technician	0.0	1.0
AUDIOLOGY TOTAL		1.3
COMMUNITY HEALTH SERVICES		
Community Health Nurse	1.0	4.0
Registered Nurse	1.0	1.0

ATTACHMENT

RAC CALCULATED UNMET PERSONNEL NEED
PAGE 3

	AUTHORIZED FOR FY 1979	PERSONNEL UNMET NEED FOR FY 1984
COMMUNITY HEALTH SERVICES (cont.)		
Nursing Assistant	0.0	0.5
Clerk typist	1.0	0.5
COMMUNITY HEALTH SERVICES TOTAL		4.0
PUBLIC HEALTH NUTRITION		
Nutritionist (the authorized nutritionist is only partially contracted from Minot, ND)	0.3	0.7
Nutrition Technician	0.0	1.0
Clerk	0.0	1.0
NUTRITION TOTAL		2.7
ENVIRONMENTAL HEALTH		
Sanitation Engineer (the authorized sanitation engineer is only partially shared from the IHS district offices in Minot, ND)	0.3	0.7
Field Sanitarian	0.0	1.0
Sanitarian Technician	0.0	1.0
Clerk	0.0	0.5
ENVIRONMENTAL HEALTH TOTAL		3.2
MENTAL HEALTH		
Mental Health Consultant	0.0	1.0
Mental Health Technician	1.0	1.0
MENTAL HEALTH TOTAL		2.0

ATTACHMENT

RAC CALCULATED UNMET PERSONNEL NEED
PAGE 4

	AUTHORIZED FOR FY 1979	PERSONNEL UNMET NEED FOR FY 1984
SOCIAL SERVICES		
Social Worker Associate	0.0	1.0
Clerk	0.0	1.0
SOCIAL SERVICES TOTAL		2.0
HEALTH EDUCATION		
Clerk	0.0	0.5
HEALTH EDUCATION TOTAL		0.5
C.H.R. PROGRAM		
Community Health Representative	15.0	7.0
C.H.R. PROGRAM TOTAL		7.0
CALCULATED UNMET PERSONNEL NEED GRAND TOTAL		51.4
		($170,600.00)

CONTRACT HEALTH SERVICES UNMET NEED

	AUTHORIZED FOR FY 1979	UNMET FY 1984 NEED
Contract Support of Direct Services	$ 34,650.00	$1,101,264.40
Direct Contract Health Services	787,700.00	2,084,192.00
Tribal Specific Health Plan Grand Total (Unmet Need)		$5,303,471.38

TRIBAL SPECIFIC HEALTH PLAN I

A) Using BIA population data.[1/]
B) Including Tribal Specific non-RAC EMS plan and the non-RAC Alcoholism Plan,
C) Omitting the RAC calculated EMS and Alcoholism Personnel.

1. PERSONNEL NEEDS

Type of staff required for 1984	No. of Personnel required for 1984	IHS Authorized Positions for 1979	Unmet Need for FY 1984
Primary care provides	3.4	3.0	0.4
Remaining clinical staff	23.0	10.0	13.0
Other ambulatory care services (excluding EMS staff)	21.6	5.0	16.6
Total Community Health services (excluding Alcoholism staff)	21.0	6.6	14.4
Other programs in RAC (CHR)	22.0	15.0	7.0
Total Personnel	91.0	39.6	51.4
Total costs of personnel	$1,986,000.00	$815,400.00	$1,170,600.00

2. CONTRACT CARE

Contract Dollars required for 1984	Total Dollars available for 1979	Total Unmet Dollar need
$4,010,806.40	$822,350.00	$3,188,456.40

3. OTHER PROGRAMS

Non-RAC programs required	Costs Required	Available Dollars for FY 1979	Unmet Contract Dollar Need
Health Department Facility for Health Dept. includes 3,000 for utilities for FY 1984	298,281.00	-0-	289,281.00
Alcoholism Program (non-RAC)	144,750.00	-0-	144,750.00
EMS Plan	316,964.70	55,418.00	216,546.70
Total other Programs	248,837.28	-0-	248,837.28
	999,832.98	55,418.00	944,414.98

4. TOTAL HEALTH COSTS for parts 1,2,&3 — $6,996,639.38 — $1,693,168.00 — $5,303,471.38

ATTACHMENT 3

ADDITIONAL MATERIAL FOR THE RECORD

I. SPECIAL GEOGRAPHIC AND HISTORIC PROBLEMS

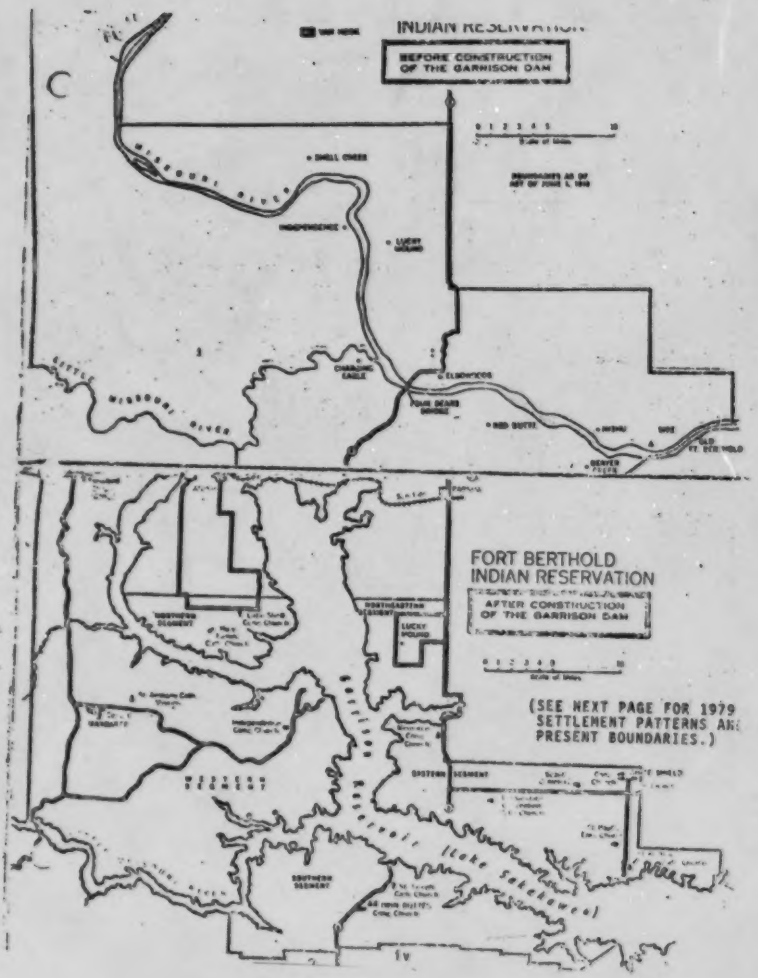
The distribution of health care services must be tailored to the needs of the populations serviced.

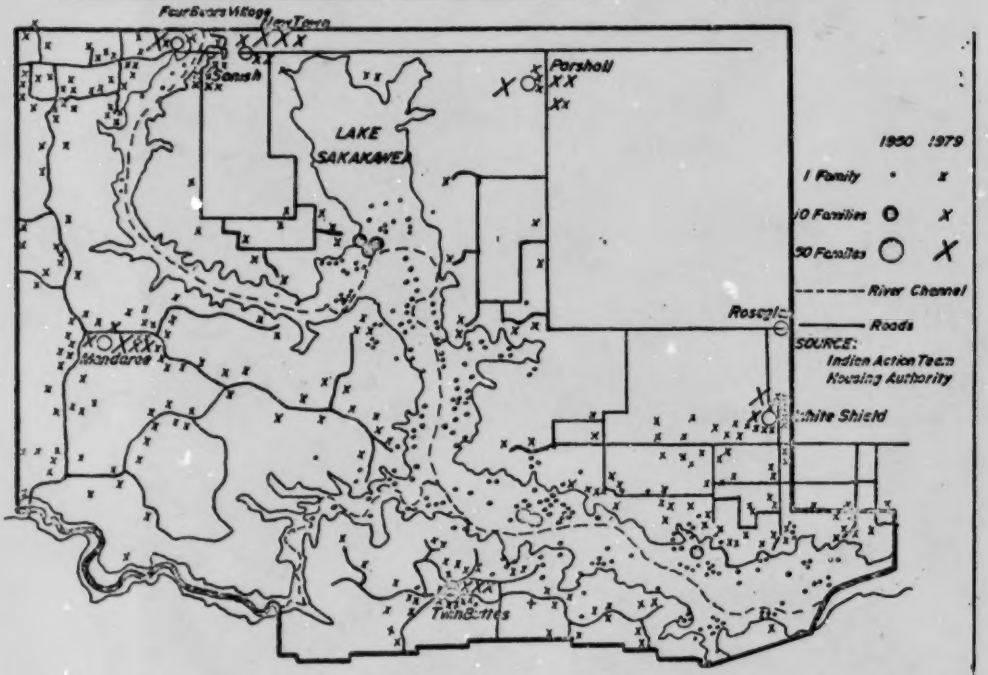
The Fort Berthold Indian Reservation presents a very difficult but not impossible case for the distribution of health services. The six (6) Indian communities are distributed in the most varied and complex of geographical settings of North Dakota with the badlands in the West and an invasive large man made lake (the Garrison Dam) in its center[1/]. With the flooding of the reservations bottomlands in 1954 resulted in a great corresponding loss of economic independence. The Three Affiliated Tribes has since depended heavily on federal programs to maintain the majority of their economic, health, and educational needs.

Because of recent legislation, Public Law 94-437, the Indian Health Care Improvement Act, there was hope, as was shared among other Indian Tribes, that the level of health care would be improved for the Indian populations who would have input into their health planning to meet these needs.

The health status of the Three Affiliated Tribes remains below the national average as demonstrated by the statistics compiled in our Tribal Specific Health Plan. It was during the development of these health plans that a need greater than other non-Indians and Indian populations was verified by Indian Health Services statistics.

1/ See Fort Berthold Reservation maps on page 2 and 3.


INDIAN RESERVATION
BEFORE CONSTRUCTION
OF THE GARRISON DAM
MISSOURI RIVER
SMALL ONES
INDEPENDENCE
LUCKY MOUND
CHARGING EAGLE
ELBOWOODS
FOUR BEARS BRIDGE
RED BUTTE
DENVER POINT
OLD FT. BERTHOLD
FORT BERTHOLD
INDIAN RESERVATION
AFTER CONSTRUCTION
OF THE GARRISON DAM
LUCKY MOUND
NORTHEASTERN SEGMENT
NORTHERN SEGMENT
EASTERN SEGMENT
SOUTHERN SEGMENT
(SEE NEXT PAGE FOR 1979
SETTLEMENT PATTERNS AN
PRESENT BOUNDARIES.)



FORT BERTHOLD RESERVATION
SETTLEMENT PATTERNS

This was reflected in the higher morbidity and mortality rates,[2/] the constant lack of health professional staff and contract funds to meet needs of service area. The net translation of these statistics means that in proportion to other non-Indian and Indian populations the situations at Fort Berthold is serious. This also indicates a greater amount of loss of life and human suffering for our reservation population which may not be necessary were adequate health care delivery available.

II. TRIBAL HEALTH PLANNING

It is for these reasons that the Three Affiliated Tribes has decided to impliment the Indian Health Service's capability for health planning by contracting a well known health consultant to do a long range in-depth and comprehensive feasibility study of our health services.

This project is contracted with Don Jennings & Associates has been several months in process with a great deal of critism, review and input from our tribal administration and planning staff. This feasibility study is now completed.

We hope that local and Congressional representatives will be able to examine our efforts and plan to impliment a cost effective system for our reservation's long range health needs. The presentation of this material should be forth coming to state and federal persons and agencies this year.

2/ Morbidity and mortality information given on page 5-8 was compiled from Indian Health Services and is in the Fort Berthold Tribal Special Health Plan, April, 1979, pages 34-37.

TABLE B3

LEADING CAUSES OF DEATH

Ten leading causes of death for Indians for Aberdeen Area[1] compared with Fort Berthold[2] 1974 to 1976.

	Fort Berthold	Aberdeen	Fort Berthold Rates Per 100,000	Aberdeen
All Causes	89	1,803	1,234.2	1,208.1
Accidents:	25	363	246.7	243.2
Motor Vehicle	20	225	277.4	150.8
All Other	5	138	69.3	92.5
Disease of Heart	19	355	263.5	237.9
Malignant Neoplasms	11	142	152.5	95.1
Cirrhosis of Liver	5	107	69.3	71.1
Cerebrovascular Disease	-	72	-	48.2
Influenza and Pneumonia	-	92	-	61.6
Suicide	-	42	-	28.1
Certain Causes of Mortality In Early Infancy	-	77	-	51.6
Homicide	-	60	-	40.2
Diabetes Mellitus	3	47	41.6	31.5
All Other Causes	26	446	360.6	298.8

Source: Table 16. From IHS Information packets for Tribal Specific Comprehensive Health Plans Data

Source: Table 18. From IHS Information packet for Tribal Specific Comprehensive Health Plans Data

TABLE B4

SUMMARY MORBIDITY DATA FOR FORT BERTHOLD

FORT BERTHOLD - POPULATION 1978 = 2,600[2]
Rate /1000 Population for Ambulatory Patient Care Visits

1.	Supplemental	.8692
2.	Dis. of Respiratory System	.7958
3.	Endocr., Nutr., and Metab Dis.	.6258
4.	Dis. of Skin and Subcutaneous Tissue	.4508
5.	Dis. or the Circulatory System	.3858
6.	Accidents, Trauma and Adverse Effects	.3554
7.	Symptoms and Ill-Defined Conditions	.3258
8.	Musculoskel. System and Connect Tissue	.2538
9.	Ear Diseases	.1981
10.	Dis. Digestive System	.1369

Rate/1000 Population for Inpatient Discharges

1.	Diseases of the Respr. Sys.	.048
2.	Accidents, Poisonings and Voilence	.038
3.	Pregnancy Child Birth and the Puerperium	.034
4.	Disease of the Digestive System	.021
5.	Mental Disorders	.016
6.	Infective Parasitic Disease	.012
7.	Disease of the Circ. System	.012
8.	Disease of the Skin and Subcutaneous Tissues	.009
9.	Symptoms and Ill Defined	.001
10.	Endocrine, Nutritional and Metabolic Disorders	.001

2. Information from Population Statistics Branch Office of Program Statistics Indian Health Service, Septembe 1977.

TABLE C1

MAJOR AMBULATORY HEALTH PROBLEMS

DATA TAKEN FROM TABLE B1

1. Diabetes Mellitus (1,408)
2. Upper Respiratory Infection (1,013)
3. Hypertensive Disease (680)
4. Pharyngitis, Tonsilitis (Non-Strep) (460)
5. Eczema, Urticaria or Skin Allergy (360)
6. Other Diseases of Skin (271)
7. Dislocation, Sprain and Strain (258)
8. Acute Otitis Media (251)
9. Influenza (250)
10. Laceration or Open Wound (218)

TABLE C2

MAJOR INPATIENT HEALTH PROBLEMS

DATA FROM TABLE B2

1. Acute Upper Respiratory Infection (57)
2. Delivery Without Complication (52)
3. Pneumonia (21)
4. Diarrhea Disease; Cause Unknown (21)
5. Intracrainial Injury (19)
6. Contusion, Crashes with Skin Injury (19)
7. Diabetes Mellitus (18)
8. Other Diseases of the Digestive System (17)
9. Gastritis, Duodenitis (15)
10. Acute Bronchitis, Bronchiolitis (15)
11. H/E Chronic Alcoholism (14)
12. Acute Alcoholic Intoxication (14)

III. TITLE III REQUEST

Section 302 of Title III of PL 94-437 with "Construction of Safe Water and Sanitary Waste Disposal Facilities." The Three Affiliated Tribes realizing the limited funds allotted to the Tribes under P.L, 86-121[3/] is requesting sanitary and safe water construction be allowed for 25 proposed HIP projects on the reservation. The estimated cost per a project is aproximately $8,000, so the total cost associated with the HIP improvement will be about $200,000 for FY 1981.

Justification is indicated because the need for utilizing all available housing is becoming more critical as the backlog in housing construction continues.

Although no definite housing growth rate statistics are available Western North Dakota especially the area on and near Fort Berthold Reservation may be the heaviest impacted area for Coal and Oil development in the United States, The greatest rate of acceleration of this impact should be experienced in the summer of 1980.

Many of the families on the reservation are already living in overcrowded low rent houses near the central communities of Mandaree, Twin Buttes, Four Bears Village, New Town, Parshall, and White Shield. The use of funds under this section will allow some of these crowded families to relocate to the improved HIP homes which will have the adequate water

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3/ See Attachment A page 12 of this shortage in sanitary facilities construction.

and sewage requirements.

This FY 1981 request then should be coordinated with the assessed needs projected by our Indian Health Service, OEH, Field Engineer, Richard Melton in Minot, North Dakota. The remaining three (3) years FY 1981-1984) of distribution of P.L. 94-437's unmet needs should then be projected by Indian Health Service and fully appropriated under this section.

Three Affiliated Tribes Health Care Resolutions

Also included in this Testimony are two (2) Tribal Resolutions included in attachments A, B, & C, pages 13 and 15.

The Resolution included in Attachment A & B summarize additional information to be attached to our Tribal Specific Health Plan.

The resolution included in Attachment C states the Three Affiliated Tribes decision to impliment the Medicare Program for the elderly members of the Fort Berthold Reservation.

IV. Corrections: (This Section is to be changed from the March 28th Testimony but not included in this submitted Written Testimony)

Please not the following corrections and supported material for the Testimony submitted at the U. S. Senate Hearings at Billings, Montana on March 28, 1980 on PL 94-437:

On page 5 of the Fort Berthold Testimony:

Correction #1: Item (1) Under Specific Action

"1. 51.4 positions at a cost of $170,000.00" should read:

1. 51.4 positions at a cost of $1,170,000.00.

Correction #2:

"Resulting in a total unmet need is $5,303,481.28" should read:

The resulting total 1984 unmet need is $5,303,471.38.

Correction #3:

The footnote "IBID" should read:

2/ See Attachment (5), Fort Berthold Tribal Specific Health Plan, page 129.

On the Attachment page 4 Correction 4:

"Calculated unmet Personnel need Grand Total 51.4 ($170,000.00) should read

Calculated unmet Personnel need Grand Total 51.4 ($1,170,000.00)

Enclosed is a copy of the complete written Testimony which is corrected with the additional attachments. Also all attachments have also been numbered to facilitate these references.

ATTACHMENT A
Page 12

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

March 20, 1980

ABERDEEN AREA
INDIAN HEALTH SERVICE
FEDERAL BUILDING
ABERDEEN, SOUTH DAKOTA 57401

Our ref: Office of Environmental Health

Mr. Austin Gillette, Tribal Chairman
Three Affiliated Tribes Business Council
New Town, North Dakota 58763

Dear Mr. Gillette:

This is to acknowledge receipt of your project proposal dated February 19, 1980, requesting assistance under P.L. 86-121 to provide sanitary facilities to homes improved under the HIP program.

The Indian Health Service budget for FY 80 has a projected shortfall of approximately $22 million. Because of the shortage of funds, it has been necessary to prioritize the funds received. The highest priority, service to new HUD and HIP units, will require the entire 1980 allocation. No existing funds are available to provide service to HIP renovations.

The Indian Health Service has requested a supplementary appropriation to serve additional housing units. Whether this effort is successful cannot be projected at this time.

We understand and share your concerns in providing for this important service. Our Field Engineer, Rich Melton will keep you informed of the status of the funding. Please feel free to contact the Minot District Office or our Aberdeen Office of Environmental Health if you have any additional questions regarding this matter.

Sincerely,

E. S. Rabeau, M.D.
Acting Director
Aberdeen Area Indian Health Service

cc: Dist. Engineer, Minot--Christensen
Field Engineer, Minot--Melton
Sanitarian, Minot--Noonan
OEH, Headquarters
SUD, New Town

65-481 O - 80 - 4

ATTACHMENT A
Page 13

Resolution No. 79-257

RESOLUTION OF THE GOVERNING BODY OF
THE THREE AFFILIATED TRIBES OF THE
FORT BERTHOLD RESERVATION

WHEREAS, This nation having accepted the Indian Reorganization Act of June 18, 1934, and authority under said Act; and

WHEREAS, The Constitution and By-laws of the Three Affiliated Tribes authorizes and empowers the Tribal Business Council to engage in activities for the welfare and benefit of the Tribe and tribal members; and

WHEREAS, The Three Affiliated Tribes has developed a Tribal Specific Health Plan and forwarded to the Aberdeen Area Office, and

WHEREAS, the unmet health needs of the Three Affiliated Tribes are great and have not been fully covered in the Specific Health Plan, and

WHEREAS, The Indian Health guidelines had restrictions which did not allow fully documentation of unmet needs, and

THEREFORE BE IT RESOLVED that the following are areas of concern and need on the Fort Berthold Reservation and not fully covered in the Specific Health Plan:

1. Authorized positions for primary care providers for the Fort Berthold Reservation be filled immediately; and

2. Contract care funds increased to meet total years need rather than depending on supplemental appropriations each year;

3. Outlying clinics at White Shield, Mandaree, and Twin Buttes be fully staffed for 24 hour service with Family Nurse Practitioners/ Physician Assistants and other staff;

4. Any addition of IHS appropriations for Fort Berthold is absorbed by rising costs and minimum service is provided for the Fort Berthold Reservation;

5. The Specific Health Plan requires use of IHS census for the Fort Berthold Reservation which excluded many residents. The Bureau of Indian Affairs census is up-to-date and gives accurate numbers of residents and should be used for the Health Plan.

CERTIFICATION

I, the undersigned, as Secretary of the Tribal Business Council of the Three Affiliated Tribes of the Fort Berthold Reservation, hereby certify that the Tribal Business Council is composed of 11 members of whom 7 constitutes a quorum, 9 were present at a Special Meeting, thereof duly called, noticed, convened and held on the 22 day of August, 1979; that the foregoing Resolution was duly adopted at such meeting by the affirmative vote of 9 members, 0 members opposed, 0 members abstained, and that the said Resolution has not been rescinded or amended in any way.

ATTACHMENT B
Page 14

Page 2
Resolution Number 79-259

Dated this 22 day of June, 1979.

Chairman (voting) (~~not voting~~).

Lilie Hall
SECRETARY, TRIBAL BUSINESS COUNCIL

ATTEST:

Austin H. Dillette
CHAIRMAN, TRIBAL BUSINESS COUNCIL

ATTACHMENT C
Page 15

RESOLUTION # 79 - 37

RESOLUTION OF THE GOVERNING BODY OF THE THREE AFFILIATED TRIBES OF THE FORT BERTHOLD RESERVATION

WHEREAS, This Nation having accepted the Indian Reorganization Act of June 18, 1934, and authority is under said Act; and

WHEREAS The Constitution and By-Laws of the Three Affiliated Tribes authorizes and empowers the Tribal Business Council to engage in activities for the welfare and benefit of the tribes and tribal members; and

WHEREAS, The Indian Health Service has limited funds for contract care on the Fort Berthold Reservation; and

WHEREAS, The Indian Health Service Clinic is understaffed and cannot serve eligible tribal members adequately; and

WHEREAS, The elderly members of the Three Affiliated Tribes are deeply affected by the lack of adequate health services, and

WHEREAS, Medicare is available to those persons over age 65 for comprehensive health care coverage; and

WHEREAS, Those tribal members over 65 covered by Medicare are free to choose the medical services they prefer and do not have to wait long periods of time for services, and

WHEREAS, There are members of the Three Affiliated Tribes over age 65 who are not able to pay the Medicare premiums, and

THEREFORE BE IT RESOLVED, that the Indian Health Service make provision to pay the Medicare premiums for members of the Three Affiliated Tribes over the age of 65; and

BE IT FURTHER RESOLVED, that the Indian Health Service notify the Tribal Business Council the progress being made in implementing the Medicare coverage for the elderly on the Fort Berthold Reservation.

CERTIFICATION

I, the undersigned, Secretary of the Tribal Business Council of the Three Affiliated Tribes of the Fort Berthold Reservation, hereby certify that the Tribal Business Council is composed of 11 members of whom 7 constitutes a quorum, 7 were present at a Special Meeting, thereof duly called, noticed, convened and held on the 26 day of January, 1979; that the foregoing Resolution was duly adopted at such meeting by the affirmative vote of 7 members, — members opposed members abstained, and that the said Resolution has not been rescinded or amended in any way. Chairman (voting) (not voting).

Dated this 26 day of January, 1979.

Secretary, Tribal Business Council

ATTEST

Chairman, Tribal Business Council

Senator MELCHER. Next is S. Kevin Howlett. He is the director of the Flathead Tribal Health Department, St. Ignatius, Mont.

STATEMENT OF S. KEVIN HOWLETT, DIRECTOR, FLATHEAD TRIBAL HEALTH DEPARTMENT, ACCOMPANIED BY DR. LOIS STEEL, INMED PROGRAM

Mr. HOWLETT. Senator, I wish to take this opportunity to express to you and the members of the committee the concerns of the tribal health department for the Flathead Reservation.

Our health department will, in May, celebrate its third anniversary.

Our department functions principally on grant dollars allocated through Public Law 93–638.

Over the past 3 years, it is my contention that the level of concern, as well as commitment to include health care for Indian people, has dramatically increased.

We have taken the time to develop relevant, accurate data on the health care conditions on the reservation. Now that we have developed and researched the needed information on the health care conditions of the reservation, we find ourselves stifled by the inability to do anything to remedy the problem.

There cannot continue, on the part of the Government, a philosophy of paternalism and negativism toward tribal rights. The dollars the Congress appropriated for self-determination projects relative to health care has not reached the tribes. It appears there is more interest in perpetuating the ineptness of the system than there is to really address the problems defined by the tribes and substantiated by the reference to data.

There must come a point when we look at the programmatic concerns of health care and not focus our time and attention on procedural application when that has proven to be ineffective.

The concerns, I must point out, do not appear to be problems from our area office but problems that originate at the headquarters office and above in DHEW.

I will submit, as I indicated to your staff yesterday, while the record is open, such documentation so as to evidence my concerns expressed herein.

I would like to express my concerns for title I of 94–437. The Indian Health Care Improvement Act provides for a comprehensive package of health manpower development. It offers the possibility of health career awareness from the lower grades through medical school. However, funding in section 102 needs to be increased so that individual tribes can develop health career awareness in younger students and then serve as feeder systems to such programs as INMED, based at the University of North Dakota.

INMED is a health education program for Indian students from a five-State area of Montana, Wyoming, Nebraska, North Dakota, and South Dakota. Also, the health careers recruitment program located in Billings, Mont. serves Montana and Wyoming high school seniors. Such coordinated use of title I will also make the number of Indian health care professionals who will serve the health needs of Indian people. Such coordinated use of title I will also make self-determination a reality and make the remaining sections of the IHCIA more meaningful. Title I, which provides for health education, is vital if there is to be Indian health care improvement.

I would be happy to entertain any questions from the Senator.

Senator MELCHER. Well, for this current fiscal year, there is about $11 million for title I.

Mr. HOWLETT. Is that authorized or appropriated?

Senator MELCHER. That has been authorized. What do you think it should be, or do you have an opinion on that?

Mr. HOWLETT. Senator, I would like to defer that question to Dr. Lois Steel from the INMED program. Being an M.D., I think she would be in a better position to answer that.

Dr. STEEL. I do not know how many programs are being funded under title I. I know we could use more money in our program, of course, because we have five slots, and the way the thing is now sitting, our students are forced to sign contracts when they are sophomores and juniors in college, which would tie them up with IHS before they even get into a professional school. They are telling us the reason for that is there is not enough money. We also, then, end up with our students on what is called 104 moneys, and that only goes for 4 years. Sometimes that is not enough to get people through medical school if they use 2 years of the 104 to get through their undergraduate degree, and it is leaving our students hanging in medical school.

So with that answer, I can't give you an exact dollar figure, but I know it should be increased and the authorization should be enough so we can get them adequately through school without putting them into a timeframe which is almost impossible for kids coming off the reservation.

Senator MELCHER. Do you know how much INMED received in appropriation for this fiscal year?

Dr. STEEL. It is approximately $300,00[illegible], but some of that is HCRP money and some is IHS money, so I do not know the exact dollar figures that I should know.

Senator MELCHER. Do you know how many students that covered?

Dr. STEEL. It is about 35 students, and we are also paying out-of-State tuition for students in the total five-State area.

Mr. HOWLETT. I have one additional comment that I would like to make which is not written in my testimony, but I would like to state for the record that the Flathead Indian Reservation is unique in many ways in that it is virtually an all contract care reservation. I do not feel that in the management of health care that the Government or the tribe is in a position to continue to tolerate the provision of health care simply by the payment of bills to physicians. I very strongly feel that a certain percentage of the money that is allocated to Flathead's needs should be reprogramed into an area of prevention. Many of the problems that we have on that reservation are problems that go back two, three, and four generations, and we have not been able to address those problems because we have only the ability to pay bills after the problem has occurred. I feel very strongly that the Congress, and particularly the appropriations committees, ought to take a very serious look at developing more preventive programs if we are going to address health care.

Senator MELCHER. I would agree. Thank you very much.

Next is Jessie James, tribal health board chairman, Fort Belknap Community, Harlem, Mont.

STATEMENT OF JESSIE JAMES, CHAIRMAN, TRIBAL HEALTH BOARD, FORT BELKNAP COMMUNITY, AND VICE CHAIRMAN, MONTANA INDIAN HEALTH BOARD; ACCOMPANIED BY MARVIN HEALY, SR., TRIBAL HEALTH DIRECTOR, FORT BELKNAP COMMUNITY

Ms. JAMES. I am here today on two parts, one from Fort Belknap Reservation, as a member of the tribal council, and also as vice chairman of the Montana Indian Health Board. I would like to present that statement later. That is on the 437 title I program funds. Will that be all right?

Senator MELCHER. Do you have two statements.

Ms. JAMES. Yes. This is strictly on Fort Belknap.

Senator MELCHER. All right. Please proceed.

Ms. JAMES. I won't read the total cover letter that Mr. Plumage wrote. It is to Hon. John Melcher, chairman, Senate Select Committee on Indian Affairs, and the address:

Subject: The concerns of the Fort Belknap Reservation tribes regarding Indian Health Service.

DEAR SENATOR MELCHER: This document, which will provide a brief summary of the concerns of the Fort Belknap Reservation, is being submitted for inclusion in the field oversight hearings on Indian Health Service, March 28, 1980, in Billings, Mont.

I deeply regret that I won't be able to attend these hearings as health concerns hold a top priority with me in my personal as well as official capacity. However, my elderly mother is in ill health which, since the recent death of my father, requires my first and foremost consideration. I feel certain you will understand my sense of love, obligation, and duty in this decline to travel at this particular time.

However, in my official capacity at present, and with full support of the community council, we send as our official representative Ms. Jessie James to testify in our behalf.

Ms. James—

And I won't read that particular paragraph.

Accompanying Ms. James will be Marvin D. Healy, present executive director of the Fort Belknap Tribal Health Department. Although Mr. Healy is fairly new in his present position, he has nearly 3 years experience with the Fort Belknap Tribal Health Department as the former contract/finance officer, a job in which he excelled.

We feel confident that both Ms. James and Mr. Healy will serve well in representing the health concerns of Fort Belknap.

Prior to listing our major concerns, we are requesting the indulgence of the committee in granting us an extension for submission of further, more detailed materials to document our concerns.

Again, thank you for your consideration, and I do regret that I could not meet with you personally.

Attached you will find a listing of our major concerns. If you have a need for further information, please feel free to contact me, Mr. Healy, and/or Ms. James by calling—

A phone number is listed. This is signed by Charles "Jack" Plumage, president, Fort Belknap Community Council.

The administrators of Billings Area Indian Health Service do not practice, support, encourage, or assist the tribes of Fort Belknap in the congressional intent of Public Law 93-638, which is Indian self-determination.

For years, the Fort Belknap Community Council has stated their desire and need for the construction of a new hospital at Fort Belknap.

The need for a new health facility at Fort Belknap has been well documented in our congressional presentation material submitted in 1978. The Joint Commission on Accreditation of Hospitals has stated this need for many years, since, as far back as 1968. Indian Health Service physicians and various administrators have documented for the tribe the need of construction of a new hospital to replace the almost 50-year-old structure. The community members have also voiced their desire for a new hospital.

But the Billings area office, Indian Health Service officials, have done little or nothing to assist us in this matter. We were told approximately 7 years ago that we were first on the list to receive hospital construction funds. Due to, we feel, lack of concern and push by IHS, we have lost our top ranking. Why? We are unable to secure answers from IHS in this matter.

Lack of response and cooperation. Fort Belknap enjoys very little cooperation on the local and/or area level with IHS officials in meeting the health needs of our people. For example, for the last 3 years, we have sent letters, tribal council resolutions, and personal pleas to IHS at the local, area, and national level for financial assistance to upgrade our agency water delivery system, especially in requesting of funds to clean, sandblast, and paint our blue water tower. Each year we experience problems of water contamination, due mainly to an inadequate water delivery system. We have a fairly new, sophisticated water plant, but without funds to maintain sanitary conditions of our water tower, our chlorine is eaten up, and we have contaminated water.

One response, and we receive very few, if any responses, to our communications from IHS, was that the tribe should seek out an alternate water source. Perhaps IHS is not familiar with our country, but we have only the Milk River to rely upon for agency water supply. IHS continually denies our capabilities to administer our own programs, and yet they apparently feel we have the Maker's power to create a new river.

Decentralization of Indian Health Service. Most recently, the American Indian Policy Review Commission did a study of the Bureau of Indian Affairs. The recommendations and resulting actions of that study is total reorganization of BIA and decentralization of services, et cetera, from the area level to be placed and administered at the local reservation level.

We call for that now—an evaluation, reorganization, and decentralization of the Billings area Indian Health Service programs, staff services, and dollars to the reservation levels.

In addition, we feel that reservations should have initial input in area IHS budgeting, staffing, and total operation evaluation in delivery of all services.

Indian Health Service exists to serve Indian people. How can this be a reality until we have equal authority, recognition, and actual everyday participation?

Futher concerns in the form of more detailed documentation will be submitted.

And I thank you.

Senator MELCHER. What is the status of the hospital right now?

Ms. JAMES. That is a really good question. I have asked that. I have asked what the future plans are for the present hospital that we have.

I have asked to see where we are on that priority list, and I still have not received a clear answer.

Senator MELCHER. My question is what is the status of it now? How is it operating as is?

Ms. JAMES. It is falling apart is what it is. They have used medicaid and medicare money to make a few adjustments. I guess what they call it is renovation.

Senator MELCHER. How many beds are there now in use?

Ms. JAMES. I think there are probably 16. I am not too sure.

Senator MELCHER. Sixteen?

Ms. JAMES. Yes, sir.

Senator MELCHER. Are there Indian Health Service physicians operating there?

Ms. JAMES. Yes, sir. I think that we have really good physicians up there now, but the physicians, too, are the ones who are saying you could retain more doctors here if you had a better hospital. This hospital is just simply not adequate. We have all that in our documentation that we sent in, in which we requested a new hospital.

Senator MELCHER. How many of the tribal members live in Hays or right around Hays?

Ms. JAMES. The population, I imagine, would be about 500.

Senator MELCHER. In that general vicinity?

Ms. JAMES. Right, and they all travel to Fort Belknap.

Senator MELCHER. Which is 80 miles?

Ms. JAMES. Right, and that is pretty bad road. Also, we have attempted to get a walk-in blood bank started because we lose a lot of patients due to loss of blood, and we were not able to do that. They said there was no way we could do that because there was no way for storage. I do not know how you storage walk-in people.

Anyway, we really have a lot of problems. I do wish that you could come up and take a look at it.

I have to add something else, too. Last Monday, my daughter was put in the hospital. The doctor said, "I won't lie to you. She has all the symptoms of leukemia." So for one full week I stayed in that hospital. I saw an elderly lady, 69 years old, get up out of her bed, get a mop, and clean up because she had had an accident, because she rang for nurses who did not come. So I think the situation up there is pretty bad, and I keep writing down here. I keep talking to people, and it does not seem to do any good.

Senator MELCHER. What would the proposal be if funds were available for a new hospital? How many beds would it be?

Ms. JAMES. I have that material with me in my briefcase. We requested $10 million. We wanted a tribally controlled, community hospital, and I have all that material with me if you would like to look at it later.

Senator MELCHER. Yes. We would like to have it.

Now, do you have some testimony you would like to submit on——

Ms. JAMES. The gal that is going to give it with me—I would like to get with her first, and that is with the health careers program that they have down here.

Senator MELCHER. Would you want to do that now or later?

Ms. JAMES. I would like to do that later, if that is all right.

Senator MELCHER. Yes.

Ms. JAMES. I think that Mr. Healy, as the director of the health department, has a question for you.

Mr. HEALY. The question I have is why do we not now have funds for the indirect costs to support our programs? It seems that money was available at the beginning of the year, and now after the establishment of new indirect cost rates, suddenly there is no money.

Senator MELCHER. We will have to find out for you.

Thank you both very much.

Our next witness is Caleb Shields, tribal council member, Fort Peck Tribe, Poplar, Mont.

STATEMENT OF CALEB SHIELDS, TRIBAL COUNCIL MEMBER, ACCOMPANIED BY RICHARD COURCHENE, TRIBAL HEALTH DEPARTMENT, AND NATHANIEL LONG HAIR, TRIBAL COUNCIL MEMBER, FORT PECK TRIBE

Mr. SHIELDS. Good afternoon, Senator. I am Caleb Shields. With me to my left is Richard Courchene. He is a professional staff person of our tribal health department, and on our far left is Nathaniel Long Hair, a tribal council member of the Fort Peck Tribe and also a member of the HEW committee.

I believe you have with you the testimony of the Fort Peck Tribe. For the record, I would like to read our tribal chairman's front cover letter.

It says:

HON. SENATOR MELCHER: If it pleases your purposes, this testimony is a document prepared by the tribal officials dealing directly with the health service delivery on the Fort Peck Indian Reservation.

Improvement of the means by which delivery of health care to the native American Indian people, and ultimately, the delivery of health care to Indian people by Indian people is our prime concern. Implementation of Public Law 93-638 program functions brings us nearer to that goal. Particularly in the area of health service delivery, our efforts are enhanced by legislation that is supportive, by design, to the status we seek, Indian self-determination.

The reauthorization of Public Law 94-437, the Indian Health Care Improvement Act, would further promote our present and planned health program operations. The legislative enactment that shall follow will most definitely assist us in our tasks toward self-sufficiency in administration and management of our own affairs.

Undoubtedly, a sensitive ear shall hear the voicing of the attached unmet needs. It is to be remembered that the reason for much of the yet unmet needs is insufficient appropriations and professional personnel to take on the ominous task of total health care delivery to all of native American Indian people.

Continued congressional support is very necessary, and we thank you for your time in the matter of conducting these oversight hearings.

Sincerely,

NORMAN HOLLOW,
Chairman, Fort Peck Assiniboine and Sioux Tribes.

Next, Senator, we have the testimony, and I would like to continue with that.

Senator MELCHER. Surely.

Mr. SHIELDS. Honorable Senator Melcher and respectable members of this committee, we are pressed with issues weighing whether to reauthorize the pursuits of the intents of the congressional enactment of Public Law 94-437 and subsequent efforts designed to negate insufficiencies in the delivery of health care to the native American Indian people of the United States and, more specifically, the Fort Peck Assiniboine and Sioux Tribes.

Current indications are strongly emphatic to a posture of consistent lack of significant improvement of service delivery, which is to say that the goal of the mandates expressed in the language of the legislation in question have not been satisfactorily attained. Therefore, continued development of improvement in health care service delivery must, in our judgment, be permitted to prevail at the level presently provided for, for further improvement in systems of delivery by present authorization in the act's entitlements. Expanded program development should be emphasized in certain disciplines and provided for by reauthorizing of the mandates of the act. A positive assertion of this type on the part of the lawmaking body of this Nation would spawn new levels of confidence in the native American peoples that it truly is the desire of the governmental structure to make accessible the highest possible health status to Indians and to reaffirm the commitment to provide existing Indian health services with all resources necessary to effect that policy.

It is important to our people and health programs, current and planned, to stress the necessity for Indian health administrators to establish health care priorities and address the unmet needs logistically, according to severity.

On the Fort Peck Assiniboine and Sioux Reservation, alcoholism rehabilitation and treatment is regarded as the most severe unmet need. Reauthorization of Public Law 94–437 would retain the mechanism to channel funds to the tribal programs' level to secure a facility which would house a total and complete alcoholism component.

It has been suggested that a more appropriate review panel for proposals that are submitted to monetarily support alcoholism rehabilitation and treatment programs be established and authorized instead of the Office of Alcoholism of Indian Health Service presently headquartered in Albuquerque, N. Mex. It was further recommended that the committee on alcoholism of the National Congress of American Indians be the authorized conduit agency for all Indian alcoholism and chemical dependency programs nationally. The reason being that under the present system, policies are being promulgated by non-Indians who do not understand the total philosophy of the ethnic ramifications in relation to the problem. Contracting directly with the national funding resource agency is desired, thereby omitting the need for many middlemen and promoting the least restrictive method alluded to in the language of the Public Law 94–437 enactment. It is felt that Indian alcoholism programs could best be administered if authorized to enjoy the formula grants status that is enjoyed by State governments in funding considerations.

The socioeconomic pressures are such that in these times it is important that mental health programs should be in full-force operation. Instead of continuity in services at a time when conditions are worsening, there exists an understaffed mental health component that is of skeleton strength and with no professional level leadership. Therefore, there is an unmet need of considerable proportion. These mental health counseling capabilities would be highly beneficial to efforts expended toward family cohesiveness and related problems dealing with the alcoholic syndrome. At this time, it is recognized that the Indian Health Service unit's personnel deficiencies in mental health at the Fort Peck Indian Reservation must be rectified.

In the area of sanitation and environmental health, there remains an unmet health need that absolutely must be corrected. Solid waste and sewage disposal systems and wholesome water supply deficiencies still persist, mainly because necessary corrective appropriations have not been made available. The resultant disease-spreading vector problem exists at near unmanageable proportions at the Fort Peck service unit regarding the present unhealthy level of sanitation conditions and the unmet need, yet to be regarded inconsistent with the Indian health care improvement intent of Public Law 94–437.

Construction of a live-in facility to house a community nucleus for the aging or elderly and medically indigent could be realized through mechanisms of Public Law 94–437 once reauthorization is effected.

In geographically remote and climatically unappealing areas such as is the Fort Peck Indian Reservation's locale, there needs to be more attractive salaries or benefits provided for the professional personnel to effect a better percentage rate of retention. Attrition in the physician and medical support staff area is high.

Resource allocations, both in personnel development and financial support, must be made to be more closely responsive to, and commensurate with, the actual and real needs as defined by program personnel in the program areas of alcoholism rehabilitation and treatment, sanitation improvement and environmental health program functions and construction, and the mental health program application area.

Direct involvement of tribal health executives with service unit and area policymaking decision processes of Indian Health Service is needed which should incorporate the engagement of the IHS officiating officer in the concerned matter at hand, the tribal health executive director, and appropriate local health board representation. This would promote knowledge, increasing participation of operations, and provide a finger on the pulse of real and defined unmet health needs. Public Law 93–638, the Indian Self-Determination and Education Assistance Act's legislative intent and the inherent goals shall be actively pursued in that this shall promote a climate that will readily lend itself to the eventual transition of IHS responsibility to the assumption by the tribes of administrative authority in health care service delivery.

A direct periodic evaluation of the meeting of mandated responsibilities stated in Public Law 94–437 by IHS is needed. All requirements must be met in public health and Indian health service laws. Close examination of alternate methodologies to exact this evaluation may possibly be alternative courses that are presented by monitors from Health Services Administration or an advisory council of a certain nature designed to specifically issue recommendations where deemed necessary by their observance of unmet needs in relation to mandates of Public Law 94–437.

All things concluded and clearly stated, you have the testimony in this hearing from the Assiniboine and Sioux Tribes of the Fort Peck Indian Reservation.

If there are questions, I will provide clarification. Thank you for your patient consideration and time.

And also, Mr. Chairman, as the Fort Peck Tribe is a member of the Indians Into Medicine program of North Dakota, we respectfully

request that this testimony of the Indians Into Medicine program be submitted on behalf of INMED.

Senator MELCHER. Yes, we will accept that testimony. We are pleased to have it, and we will make it part of the record after your testimony. [See p. 61.]

The Indian Health Service has taken over, I think, in excess of 85 alcoholism programs during the past several years. Has that happened at Fort Peck?

Mr. COURCHENE. Yes, sir. The transition has administratively taken place. IHS now has the responsibility, which was the responsibility of NIAAA, and then, I think——

Senator MELCHER. Do you think it is a better move?

Mr. COURCHENE. For some, it may have been, but talking to the administrator of the Alcoholism Detoxification Rehabilitation and Treatment Center there on the Fort Peck Reservation, he indicated to me that for various reasons, that the philosophy that they must engage in, that is, traditionally and culturally foundation based, it is a little too structured. It is not as flexible, thereby not the least restrictive method to go ahead and perform that function.

Senator MELCHER. Caleb, you testified you think it should be improved to block grants. Is that to remove some of the inflexibility, or do you think you would cut out some of the middlemen draining away the funds?

Mr. SHIELDS. I believe it is a matter of how you approach and look at the management of ANA block grants. There is quite a concern of the massive amounts of layers of bureaucracy that exists, and it could be feasible if undertaken as it was looked at.

Senator MELCHER. Once a program is accepted, it seems to me that a grant would be the cleanest way and most efficient way of utilizing the funds. I do not know how much money actually in that program would be drained away by management rather than actually getting into the running of the program itself. Can you give me any idea, any indication where the percentage of the money actually is structured into the management of the program rather than the actual carrying on of the program?

Mr. SHIELDS. Well, if you use as a guide, all types of programs throughout the United States, management, personnel salaries, whatever, it is usually absorbed in excess of 80 percent of any budget.

Senator MELCHER. Yes; but I am just talking about this alcohol program on the Fort Peck Reservation right now. Would you think that 80 percent would be drained away just in management and salaries?

Mr. SHIELDS. I think, initially and probably continually, Senator, that what was needed was professionalism in handling a lot of the alcohol programs, and as we all know, professionalism has a price on it.

Senator MELCHER. When you get the professionalism, No. 1, does the program have professionalism, in your judgment, right now on the Fort Peck?

Mr. SHIELDS. For alcoholism, you are talking through IHS or through our tribal program?

Senator MELCHER. Well, I understand what you have is an IHS-run alcoholism program. Is that correct?

Mr. COURCHENE. The funding mechanism is through IHS.

Senator MELCHER. Who is actually running the show?

Mr. SHIELDS. We have a tribal program director.

Senator MELCHER. So we have left IHS at that point. Do you have the professionalism in your director?

Mr. COURCHENE. For Indian rehabilitation things, yes. You could not take a clinician out of a non-Indian community and put him in there and expect the rate of success that he has enjoyed.

Senator MELCHER. Is it succeeding?

Mr. SHIELDS. Yes, sir.

Senator MELCHER. How much does the whole program cost?

Mr. SHIELDS. That we have presently?

Senator MELCHER. Yes.

Mr. SHIELDS. I do not know. We have a specific health planner here from the Fort Peck Reservation.

Mr. COURCHENE. We will make the costs a matter of record for you.

Senator MELCHER. Well, do you have it right there for the alcoholism program?

Mr. COURCHENE. Included in this tribal specific health plan is the specific amounts and what the projections are for the next years through 1984 which is, incidentally, a mandate of 437 in preparation of such a document. This is the tribal health system——

Senator MELCHER. Does that document include what is being spent in 1980 for the alcoholism program?

Mr. COURCHENE. Yes, sir.

Senator MELCHER. Fine. We would appreciate your submitting that.

Now, Caleb, you said that, in talking about sanitation environmental health, you talk about the resultant disease spreading vector problem that exists at near unmanageable proportions at the Fort Peck service unit. Now, tell me what you mean by "disease spreading vector."

Mr. COURCHENE. May I clarify that, Senator?

Senator MELCHER. Yes, please.

Mr. COURCHENE. You know what cockroaches and rats and mice can do in spreading of diseases when garbage is not picked up on a regular basis.

Senator MELCHER. Now, just slow down. Are you saying that you have cockroaches?

Mr. COURCHENE. Oh, yes. They came in with some wood, some materials that came in for construction of housing. They came in on the train.

Senator MELCHER. Now, have you rats?

Mr. COURCHENE. Yes, sir. That is grain country, and around all of the elevators there are rats. When things get tight there, they go to the refuse disposal, piles of garbage, because we don't have the garbage trucks or crews that are funded to pick these up on a regular basis. The individuals living in the homes are responsibile to see to that themselves because most of them live outside the responsibility of the city, say, for instance, Wolf Point, where there are tribal houses. They are not regarded as a part of the city because, on the west end, they are just outside the city limits to the south. That is tribal land, so it is not city consideration.

Senator MELCHER. Are you talking about specific diseases?

Mr. COURCHENE. Whichever disease any of those vectors carry, such as cockroaches, or mice, or even dogs that get into the garbage and go play with kids later. That, too, is a problem.

Senator MELCHER. Well, you know, a lot of this stuff is not very appetizing but not necessarily spreading disease.

Don't put this on the record.

[Discussion off the record.]

Senator MELCHER. Back on the record.

Mr. COURCHENE. Because of the refuse situation as it is, garbage is permitted to pile up for longer lengths of time and is thereby a breeding ground for cockroaches and mice, and the cockroaches get plugged up in the sewers. When they go in to spray, they get 15 gallons out of one household unit.

Senator MELCHER. The tribe asked for $383,000 for sanitation projects for this current year. Did you get it or not?

Mr. COURCHENE. No, sir. There were, as I understand, no appropriations in the environmental health portion of the service unit because they were not available at the area level or because they were not available on the national level. I do not know. But because it was not of crisis proportion, we addressed special appropriations to see if we could get the money for a sewage pumping unit, also, for septic tanks that were faulty.

Senator MELCHER. Are you renewing your application, or have you renewed your application for this year?

Mr. COURCHENE. I tried to look into it to see what the status of it was. It deadened somewhere, as I understand, because at the time they asked, on the national level, "Well, what's the deal?"

We said, "Well, we have $100 million appropriated, and we are now submitting requests for further appropriations for $50 million."

So then, it was assumed by those who are making a dollar-sign decision, "Well, that should certainly be enough to meet those needs, demands," when, in fact, those moneys were already earmarked for other purposes, and those other purposes, I believe, did not include sanitation considerations such as cockroaches and pumping septic tanks.

Mr. SHIELDS. Senator, the gist of our testimony is being graded in priority, as was stated in here, of severity. And as you probably noticed, we put a lot of emphasis on alcoholism and rehabilitation treatment, unlike other areas and organizations, tribes, what-have-you, admitting on paper that alcoholism is our No. 1 problem. We like a lot of emphasis on that No. 1 problem, and as we go down in it, we are talking now about the sanitation environment, which is very important, and solid waste sewage disposal, and water supply.

As you know, we are experiencing, up in our reservation on the Poplar River, mercury poisoning, and we are very concerned about the Poplar River; not only the poisoning, but the project as a whole. Another aspect of this is, a few years ago, Fort Peck did receive a brandnew clinic that was built, but the facility in itself does not provide services, and I think that is what we would like to get on.

Senator MELCHER. I noted in your testimony, because of the remoteness of the reservation, that it may require additional pay to hold the personnel.

Mr. SHIELDS. Health care services. It is what kind of services go on inside the facility.

Senator MELCHER. That is right.

Mr. SHIELDS. As I mentioned, salaries and benefits, there is not much we can offer up there in our particular area. More in terms of salary, benefits, or an honorary hunting permit or something. It just is not doing the job.

Mr. COURCHENE. We lost some good doctors up there because we do not have the dollar sign they were looking for.

Senator MELCHER. Are you getting help now for a limited period of time, part time, from the doctors in Wolf Point?

Mr. SHIELDS. Yes, sir. There is an arrangement they have up there of cross servicing.

Senator MELCHER. Yes; I understand that. I understand the problem very clearly.

Mr. COURCHENE. But reauthorization of the 437 concept would certainly be beneficial so we could continue to attack the problems of the unmet needs.

Senator MELCHER. I would certainly agree. I am glad you are participating and are aware and are in INMED. Thank you all very much.

[The material follows. Testimony resumes on p. 88.]

TESTIMONY:

In Fiscal Year 1979, the American Indians Into Medicine (INMED) Program became operational for continuation under the auspices of Title I of PL 94-437, the Indian Health Care Improvement Act, which provides for Indian health manpower development. The two years prior to FY '79, INMED Program support was appropriated as an add-on to the Bureau of Indian Affairs (BIA) budget. Indian Health Service (IHS) currently has the legislative authority to make grants in behalf of the INMED Program. Although this legislation has provided INMED with stability, our source of funding remains with Congress on a yearly basis.

Through the administrative support of IHS, the INMED Program has accrued a number of benefits. These include:

1. the reinstatement of the Program Advocates/Advisory Board, a reservation-based advisory group which provides direction and assistance to the Program (see TAB A);

2. the re-establishment of several important staff positions, namely the Public Information Specialist, the Educational Research Analyst, and Tribal/University Liaison;

3. the increase in the number of students supported by the INMED Program, an increase of ten students, occurred during the first year of funding under IHS without an increase in budget. A sacrifice was made in the Family Support Plan since this legislation does not allow for dependency support (see TAB B); and

4. the utilization of the externship (Section 105) to replace the INMED practicum experience.

Though we have enumerated some of the benefits, they certainly are not inclusive of the impact on Indian health manpower development. The following discussion will focus upon the quantification of students (see TAB C), i.e., undergraduate, special graduate and professional students, and finally the goal of INMED, which is to produce health professionals.

The INMED Program has demonstrated that it can provide fully qualified medical school applicants and medical school graduates. With seven years experience in Program operations and expertise in Indian health manpower development, INMED Program has a proven track record (see TAB D).

INMED has had a long standing affiliation with Congress. Through Senate Bill 2938 INMED served as a prototype for the original legislation of Title I of PL 94-437. In fact, INMED is unique in that the Program utilized all sections of Title I.

Results:

Designed to increase the number of Indians in the highest health careers, the INMED Program has been funded for Program operation and support for students earning a degree in medicine, dentistry, and the allied health professions. Since 1973, many INMED students have been admitted to medical school at UND and at various professional schools throughout the country. And each year we return to Congress with results as the following table will indicate.

This table offers a categorical breakdown of the INMED students and graduates. It shows a very successful feeder system in operation on the undergraduate level which in turn is ultimately producing fully qualified Indian physicians.

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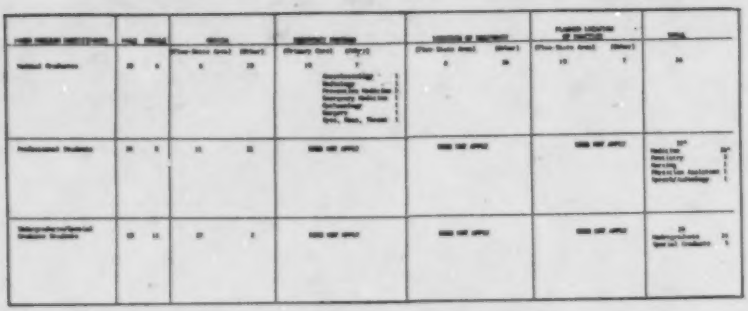
INMED Program Participants
Fiscal Year 1980



Though INMED's work is on a regional basis, the scope is a national one. Some of the reasons for the impact of our Program are:

1. From the standpoint of the consumer, resolutions of support have been submitted by the twenty-two tribes served by the INMED Program on an annual basis. Essentially this means we have the support of 100,000 Indian people from INMED's Five-State Service area (see Brochure).

2. The inclusion of the Native American culture, beliefs in Indian values, and attitudes of maintaining the traditional concepts of "family" and family ties are intergral to the INMED Program and its students.

3. The knowledge and expertise that we have gained through seven years of experience.

In conclusion, with the reauthorization of PL 94-437 for FY '81 - '84, a number of recommendations should be considered in regards to increasing the effectiveness and fully realizing the intent of Title I. The recommendations section format should allow easy visual interpretation, and will have these major headings: Sections Under Scrutiny; Proposed Recommendations; Rationale; and Justification.

Since January 1979 the INMED Program has been a supporter of the American Indian and Alaska Native Health Manpower Development Consortium. This national effort was in response to the Secretary of HEW's decision to reject the American Indian School of Medicine. While rejecting the school, the Secretary, in its place, chose an initiative of health manpower development for Native Americans.

The Consortium in their response has developed a position paper (see TAB E). INMED has included this paper and offers its support to their recommendations. We urge you to consider the consortium's efforts.

SOUTH DAKOTA	TRIBAL CHAIRMAN	INDIAN ADVISORY BOARD MEMBERS
Cheyenne River Res.	Melvin Garreaux, Chairman Cheyenne River Sioux Tribe Eagle Butte, SD 57625 Phone: 605-964-4155	James Claymore, Bd. Chm 124 Elizabeth Drive Aberdeen, SD 57401 605-229-4526 SSN: 503-52-1305
Lower Brule Res.	Michael Jandreau, Chairman Lower Brule Sioux Tribe Lower Brule, SD 57548 Phone: 605-473-5561	Everette Wilson, Member Box 31 Lower Brule, SD 57548 Phone: 605-473-5524 SSN: 501-64-8606 Orville Langdeaux, Alt. Lower Brule Sioux Tribe Lower Brule, SD 57548
Crow Creek Res.	Bob Phildrick, Chm. Crow Creek Sioux Tribe Ft. Thompson, SD 57339 Phone: 605-245-2221	Jewel Wilson, Member Crow Creek Sioux Tribe Ft. Thompson, SD 57339 Phone: 605-245-2221 SSN: 468-50-9828
Pine Ridge Res.	Elijah Whirlwind Horse Oglala Sioux Tribe Tribal Office Pine Ridge, SD 57770 Phone: 605-867-5821	Arta Carlow, Member Box 113 Pine Ridge, SD 57770 Phone: 605-867-5616 SSN: 506-32-9549
Rosebud Reservation	Norman Wilson, Chm. Rosebud Sioux Tribe Tribal Office Phone: 605-747-2387	John King, Member 797 Liberty Avenue Winner, SD 57028 Phone: 605-842-2957 605-747-2381
Santee Reservation	Andrew Weston, Chairman Flandreau Santee Sioux Trb. Box 292 Flandreau, SD 57028 Phone: 605-997-3891	Pearl Wakeman, Member 204 West 2nd Flandreau, SD 57028 Phone: 605-997-3891 SSN:
Santee Res.		Elaine Jones, Alternate Flandreau Indian School Flandreau, SD 57028 Phone: 605-997-2680 SSN: 503-52-4372
Lake Traverse Res.	Jerry Flute, Chm. Sisseton-Wahpeton Tribe Lake Traverse Res. Phone: 605-698-3911	Hiram C. Owen, Member Sisseton-Wahpeton Tribe Sisseton, SD 57262 Phone: 605-698-3911 extension 111 SSN: 503-26-9858 Gary Owen, Alternate C.H.R. Office Box 242 Sisseton, SD 57262 Phone: 605-698-3531 SSN: 504-52-0914
Yankton Res.	Larry Cournoier, Chm. Yankton Sioux Tribe Tribal Office Wagner, SD 57380 Phone: 605-384-3641	Gorden Shields, Member Box 214 Marty, SD 57361 Phone: 605-384-5783 SSN: 504-48-4464 Francis Bernie, Alternate

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TAB B

TABLE II

STATUS REPORT ON INMED STUDENTS

Comparison of Student Age and Family Size by Educational Level
Fiscal Year 1980

EDUCATIONAL LEVEL	NUMBER OF STUDENTS	AGE RANGE/MEAN	FAMILY SIZE RANGE/MEAN
Freshman	4	18-19/18.5	1/1
Sophomore	6	19-22/20.5	1-4/2
Junior	6	20-26/21.5	1-4/1.8
Senior	7	22-28/23.7	1-6/2.3
Special Graduate	6	23-24/27.3	1-4/2.7
First Year Professional	7	24-40/30.3	1-4/2.1
Second Year Medical	6	22-38/28.1	1-5/2.5
Third Year Medical	3	26-38/30.3	2-7/4
Fourth Year Medical	7	27-35/32.0	1-5/2.1
TOTAL OF ALL STUDENTS	52	18-40/26.0	1-7/2.2

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TABLE III

MEDICAL SCHOOL LIVING COSTS

Schedule of Projected Living Expenses at Medical Schools Attended by INMED Students
Fiscal Year 1980

12 Month Budget*

LIVING COSTS PER UNIVERSITY**		SINGLE STUDENT	MARRIED STUDENT	MARRIED STUDENT (1 CHILD)	MARRIED STUDENT (2 CHILDREN)
University of Alabama, Birmingham		5,580	8,760	10,560	11,760
University of Colorado, Denver		4,560	7,860	9,360	10,260
University of California, Davis	1st yr.	4,663	7,929	9,262	10,262
	2nd-4th yr.	4,007	6,867	7,800	8,734
University of Minnesota, Minneapolis		4,005	6,867	7,800	8,733
University of Minnesota, Duluth		5,733	8,267		
University of North Dakota	1st yr.	3,491	5,891	7,091	8,291
	2nd yr.	3,504	5,871	7,171	8,371
	3rd yr.	4,583	7,259	8,959	10,159
	4th yr.	5,490	8,082	9,282	10,482
University of Oklahoma		5,520	7,851	9,084	10,318
University of Texas, Southwestern	1st-2nd yr.	5,713	8,620	9,667	10,560
Medical School, Dallas	3rd-4th yr.	5,718	8,634	9,681	10,574
Washington University, St. Louis	1st yr.	3,827	6,307	8,040	9,507
	3rd yr.	3,825	6,305	7,295	8,075
Medical College of Wisconsin		5,092	9,680	10,960	12,080
Creighton University, Omaha	1st yr.	5,053	6,781	8,947	10,676
	3rd yr.	5,052	7,213	9,378	11,108
University of Arizona, Tucson		5,050	8,050	9,050	9,950
Average Budgeted Allowances		4,857	7,739	9,075	10,218
Median Budgeted Allowances		5,051	7,815	9,262	10,262
Range		3,491-5,735	5,891-9,680	7,091-10,960	8,291-12,080

*Mean and Median figures are based on 1st year medical school budgets only.
**Includes Room and Board expenses, personal and transportation allowances.

TABLE IV

NORTH DAKOTA MEDICAL SCHOOL STUDENT BUDGETS

A Comparison of Median Student Living Expenses with Budgeted Student Living Expenses*
Fiscal Year 1980

12 Month Budget

CLASS AND MARITAL STATUS		MEDIAN STUDENT LIVING EXPENSES	BUDGETED STUDENT LIVING EXPENSES	DIFFERENCES
Freshman	(Single)	$ 6,500	$ 3,491	$ 3,009 (47%)
Freshman	(Married)	10,260	5,891	4,369 (43%)
Sophomore	(Single)	4,997	3,504	1,493 (30%)
Sophomore	(Married)	8,217	5,973	2,244 (28%)
Junior	(Single)	6,013	4,583	1,430 (24%)
Junior	(Married)	11,512	7,258	4,254 (37%)
Senior	(Single)	7,775	5,490	2,285 (30%)
Senior	(Married)	12,033	8,088	3,945 (33%)

*The data was obtained from the Student Financial Aid Officer, University of North Dakota Medical School, Grand Forks, North Dakota. The budgets do not include: Tuition, Fees, Books, and other Educational Expenses.

TABLE V

FAMILY SUPPORT PLAN

A Comparison of Approved Student Living Expenses with Proposed Student Living Expenses
Fiscal Year 1980

12 Month Budget

Approved level - Based on 1977-78 Family Support Plan - BIA approved and contracted	SINGLE	MARRIED	MARRIED & ONE CHILD	MARRIED & TWO CHILDREN	MARRIED & THREE CHILDREN	MARRIED & FOUR CHILDREN
Housing	1800	1800	1800	2100	2100	2400
Food	1200	1500	1800	2100	2400	2700
Personal expenses (includes clothing, medical insurance and costs, grooming, recreation, laundry, etc.)	1470	1920	2370	2520	2970	3120
Transportation	480	480	480	480	480	480
TOTALS	4950	5700	6450	7200	7950	8700
Proposed level - 1979-80 Family Support Plan (plus cost of living increase)						
Housing	2178	2178	2178	2541	2541	2904
Food	1452	1815	2178	2541	2904	3267
Personal	1779	2323	2868	3049	3594	3775
Transportation	581	581	581	581	581	581
TOTALS	5990	6897	7805	8712	9620	10527

TABLE VI

COMPARATIVE ANALYSIS OF YEARLY BUDGETS

Comparison of Actual and Proposed Yearly Budgets Based on Family Size
Fiscal Year 1980

FAMILY SIZE	PROPOSED BUDGET	ACTUAL IHS FUNDING	DIFFERENCE	NUMBER OF FAMILIES	SUB-TOTAL
Two	$6,897	$5,436	$1,461	5	$ 8,745
Three	7,805	5,436	2,369	12	31,884
Four	8,712	5,436	3,276	4	14,256
Five	9,620	5,436	4,184	7	31,304
Six	10,527	5,436	5,091	0	-0-
Seven	11,435	5,436	5,999	1	6,287
TOTAL					$ 92,476

TABLE VII

COMPARATIVE MONTHLY STIPEND

Comparison of Actual Monthly Student Stipend Amounts According to Family Size
Fiscal Year 1980

FAMILY SIZE	TITLE IV	TITLE I
1	$500	$453
2	$575	$453
2.2*	$590	$453
3	$650	$453
4	$725	$453
5	$800	$453
6	$875	$453
7	$950	$453
8	$1025	$453

*Average family size for all INMED students, including twenty-seven single students and twenty-five students with families.

TAB C

TABLE II

Quantitative Results of the Program as They Relate to Program Objectives
Fiscal Years 1974 - 1980

PROGRAM OBJECTIVES	IMPACT/RESULTS	1974-78	1979-80	TOTAL
1. Increase awareness, interest, and motivation in health professions	Students, counselors, educators, tribal members, organizations and others contacted;	6,310	1,890	8,200
	Elementary students and parents contacted through Traveling Medicine Show (TMS)	13,000	NA*	13,000
2. Identify, recruit, and increase enrollment of undergraduates, graduates, and medical students interested in health professions	Students identified and recruited;	925	275	1,200
	Students enrolled in regular academic programs	185	65	250
3. Provide academic enrichment and reinforcement	Students provided academic supportive services;	193	57	250
	Students received advocacy;	120	35	155
	Students provided academic enrichment through Summer Institutes at high school, college, and post-graduate levels	200	30	230
4. Provide exposure to practice of medicine	College students enrolled in INMED Practicum;	10	NA	10
	High school students enrolled in INMED Practicum:	120	NA	120
	Medical students placed in clerkships, co-steps, and externships	25	6	31
5. Assist in health professional school placement	INMED students assisted;	52	10	62
	Non-INMED students provided advocacy	13	3	16
6. Identify and publicize programs and financial aids; provide educational and motivational materials	Individuals and organizations contacted through activities designed to fulfill this and the five (5) previously stated Program objectives	21,400	16,460	4,940

*NA indicates non-funded activity

TAB D

TABLE I

INMED PROGRAM HEALTH CAREER PATHWAY

Student Participants Who Have Received All or Partial Supportive Services from the INMED Program
Fiscal Years
1974 - 1980

FUNCTION	ACTIVITIES	RESULTS/ PARTICIPANTS
Medical/Professional Graduate Program	Residencies	26
Medical/Professional Education Program	Medical, Dental, MPH, Speech/Audiology, Nursing	58
Special Graduate Programs	1) Pre-professional 2) Summer Institute	25 15
Undergraduate Programs	1) Pre-professional 2) Summer Institute	145 100
Secondary Programs	1) Summer Institute 2) Practicum, 1973-1976	200 210
Elementary Programs	Traveling Medicine Show 1973-1976 (Medical exhibit, puppet show, publications)	13,000

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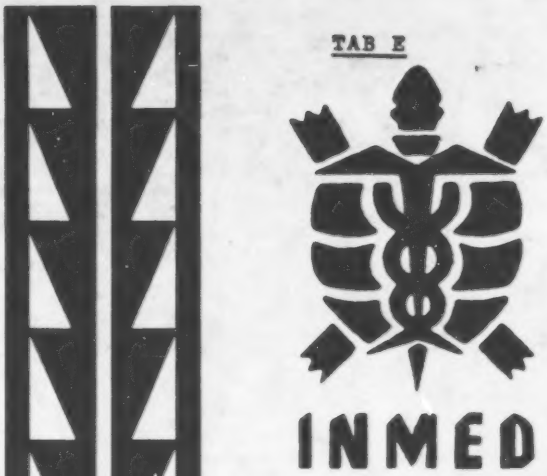
TAB E



INDIANS INTO MEDICINE

University of North Dakota
School of Medicine
Grand Forks

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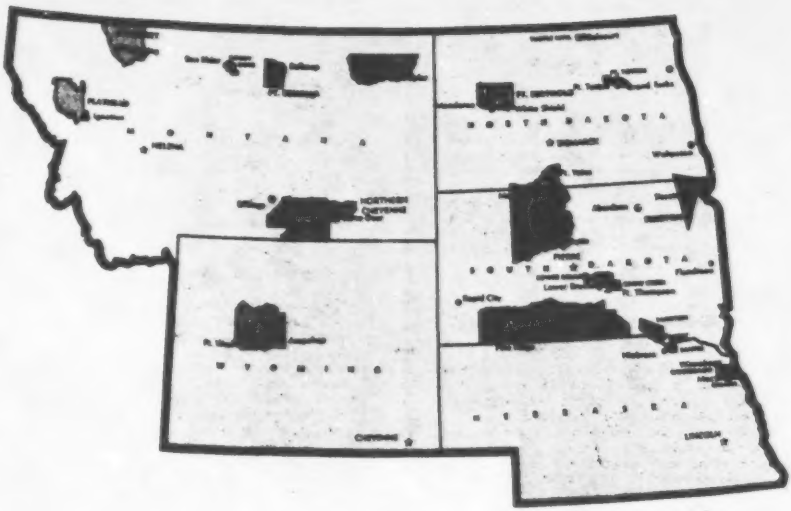


FIVE-STATE MAP
OF INMED SERVICE AREA

THE INMED PROGRAM

The Indians Into Medicine Program (INMED) is designed to produce Indian health professionals of the highest degree whose training will help answer the need for adequate health care services for Indian people. It is a reservation-based program representing 22 reservations in the five-state area of North Dakota, South Dakota, Nebraska, Montana, and Wyoming. An all-Indian advisory board appointed by the tribal council from each reservation serves in the direction and success of the Program.

INMED approaches its goal from many directions. By working with Indian communities, schools, and universities, a pool of people who show an aptitude toward a medical career is being identified beginning from the elementary school level through the college level and beyond. The junior and senior high school and college student recruitment program, another facet of INMED, draws upon this pool. Once the student enters the Program, supportive services of INMED are available to him to insure his academic success.

ACADEMIC COMPONENTS OF INMED

Medical Education Program

The University of North Dakota School of Medicine has provided the means for pursuing one aspect of INMED by granting fully qualified Indian students five positions in the School of Medicine each fall.

The 2:1:1 plan, implemented by the School of Medicine, emphasizes the training of primary care physicians and consists of freshman and sophomore years at UND, the junior year at the University of Minnesota School of Medicine or Mayo Medical School, and the final year back in North Dakota for elective clerkships at community hospitals within the state. The M.D. degree is then granted from the UND School of Medicine.

Since the fall of 1973, thirty-six INMED students have been admitted to medical school; twenty-nine at UND, and seven* at various schools throughout the country. INMED has also assisted in the placement of an additional twenty students who have chosen to complete their degrees through other medical programs.

*Including two dental students, two nursing students, and one student in a Public Health Master's Program (MPH).

Special Graduate Program

INMED also accepts graduate students who are currently not academically prepared to fulfill medical school requirements and assists them in that preparation.

To date, twenty-one INMED graduate students have completed those requirements and have been accepted into medical school.

College Program

Regardless of which health profession the INMED undergraduate chooses to pursue, the suggested premedical curriculum is essentially the same. Four years of college preparation are recommended for students entering the University of North Dakota School of Medicine, although a degree is not a requirement. No particular major is preferred, but a broad, liberal education is expected. In addition, the candidate should fit into his program the following courses: Chemistry (20 hours), Biology (8 hours), Physics (8 hours), Genetics (3 hours), Psychology or Sociology (3 hours), Language Arts (6 hours), and College Algebra (3 hours). Trigonometry, calculus, and other selected courses in biology are also recommended.

Tomorrow's physicians must not only be accomplished in medicine, but also they must be concerned with the social problems confronting the community. They need to have a liberal education, encompassing in some depth the natural sciences, the social and behavioral sciences, and the arts and the humanities. Students must therefore select their curriculum with these goals in mind.

Upper classmen and special graduate students also have the opportunity to study for the Medical College Admission Test (MCAT) through preparatory programs offered by INMED.

Since its inception, INMED has assisted more than one hundred and twenty students in their pursuit of a premedical education.

Summer Institute

INMED also assists students in their academic preparation by providing a Summer Institute program which is flexible enough to meet individual needs.

College Program

The Summer Session schedule at the University includes classes that Summer Institute students may take as part of their regular pre-medical school program. However, some students may instead choose to strengthen their academic background by taking extracurricular courses in some core areas.

High School Program

INMED offers a Summer Institute for senior high school students who show interest and aptitude in the field of health professions. To help them prepare for the college level courses they will need to take, students are provided individualized instruction in math, physics, biology, anatomy, physiology, entho-botany, chemistry, and reading and study skills.

Students receive one and one-tenth high school credits upon completion of this session.

Summer Cultural Exchange Program

In addition to their academic program, students participate in a cultural exchange program of Indian awareness topics, pow-wows, camp-outs, and other activities designed to support and maintain their cultural ties.

Approximately two hundred and eighty students have completed the programs offered through the Summer Institute.

Summer Institute activities are supported by funds from participating reservations, private foundations, and federal agencies.

SUPPORTIVE SERVICES OF INMED

Family Support Plan

The Family Support Plan is a unique part of the INMED Program. It is designed to mobilize all the human care resources required to insure the highest possible potential for success of the INMED student.

While it is expected that Indian students may have to adjust to a non-Indian academic setting, it is neither wise nor desirable to expect them to abandon their heritage and cultural values. It should not be necessary for them to have to choose between their family and culture, and an education.

Therefore, INMED students are provided with many services to meet and preserve their cultural heritage. **Financial support** in the form of student stipends covers family living costs. Freedom from financial worry enables INMED students to succeed where others failed. A planned variety of **cultural activities** are offered to help students retain their value systems and traditions. **Medical services** are provided for INMED families through University health services. **Community social service** agencies provide assistance in almost all areas of human service needs.

Counseling and Tutoring

Although special supportive services have been incorporated into the Program, the stresses that the Indian student encounters in having to meet the same pre-professional academic requirements as any other student are inevitable. INMED provides teachers and counselors to students desiring tutoring in any subject area, as well as academic or personal counseling.

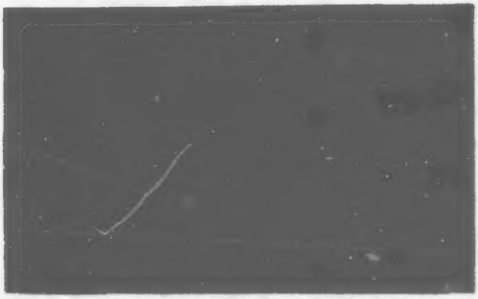
Learning Resource Center (LRC)

The LRC is designed to encourage the cultural reinforcement and academic enrichment of the INMED students. It offers students a place to meet and share their personal and professional commitments to Indian people, and affords them the opportunity to serve as role models for other Indian students. The LRC provides study areas equipped with study carrels, reference texts, and audiovisual materials to supplement their academic preparation.

The LRC also serves as a resource center for the INMED staff. Medical school catalogues, science education journals, health legislation information, and other pertinent reference materials aid the staff in assisting students toward their goals.

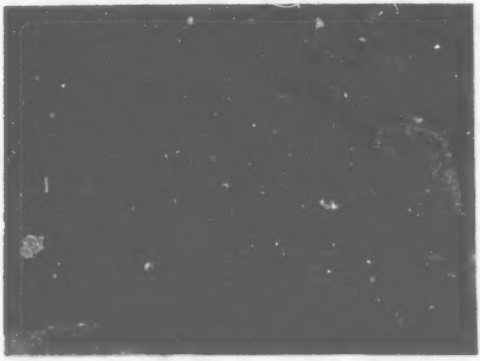
Academically Controlled Environment (ACE)

The purposes of ACE are to help students who are having a difficult time with courses in which they lack a sufficient background, and to help students who may not have developed proper study habits. Students who receive a grade of "D" or lower in the core courses are placed on probation with the Program. Conditions of probation include tutoring sessions, periodic instructors' evaluations, weekly counseling, mandatory class attendance, and individual testing to identify skill areas the students may need to strengthen.



High School Summer Institute students "taking a break."

College Summer Institute students experimenting in chemistry class



College students reviewing their physics notes

Medical student taking "time-out" for pow-wow.

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Senator MELCHER. Our next witness is Peter John Ross, assistant director, Devils Lake Sioux Tribe community health representatives, Fort Totten, N. Dak.

STATEMENT OF PETER JOHN ROSS, ASSISTANT DIRECTOR, DEVILS LAKE SIOUX TRIBE COMMUNITY HEALTH REPRESENTATIVES, FORT TOTTEN, N. DAK.; ACCOMPANIED BY RICK STRACQUALURSI, DIRECTOR, TRIBAL HEALTH PROGRAM

Mr. Ross. Senator and ladies and gentlemen. I am John Ross, assistant director of the community health representatives services program of the Devils Lake Sioux Reservation. Carl McKay, the tribal chairman, has asked me to discuss our present experience with Indian Health Service and the Indian Health Care Improvement Act before this committee.

The Indian Health Service unit at the Fort Totten Reservation consists of an ambulatory care program. Contract hospital services are purchased at a nearby 100-bed community hospital. Specialized or complex cases are referred to appropriate medical centers.

The Devils Lake Sioux Tribe recognizes the Federal Government's health services obligations through its treaty, supported by the Snyder Act and the Indian Health Care Improvement Act. Through Indian self-determination contract and tribal initiatives, the tribe and Indian Health Service work together to operate a health care program designed to maximally impact the special health care needs of the reservation community.

Let there be no doubt, the reservation's health care needs are different from those of the nearby non-Indian community. Our birth rate is approximately three times higher than average, as is our infant death rate. About one-third of the adults over the age of 35 are diabetic. Chemical abuse is far too common. Our reservation includes virtually the only community in North Dakota in which tuberculosis has been, until recently, at near epidemic levels. The tribe and IHS have developed a system of outreach and support services which will, hopefully, address these serious chronic health problems. We do not feel, at this time, that the non-IHS provider system can meet community needs.

There remain, however, certain serious problems with the IHS program. Among the more serious of these problems are: No. 1, the IHS inability to consistently recruit and retain key medical service personnel; No. 2, the IHS's unwillingness to pay contract care charges for inpatient mental health services and tribal nursing home services; No. 3, the inadequacy of contract care funding; and No. 4, the IHS lack of flexibility in program operations.

The tribe and service unit continue to work to resolve these difficulties. We are, however, constantly concerned about when one of our doctors will leave and how we will find a suitable replacement for him. We remain limited in selection of inpatient mental health services. We have encountered a seemingly endless course of obstacles in developing needed clinic facilities supported by Public Law 94–437, medicaid, or other IHS moneys. Yet, we remain optimistic of the present and future benefits of our community controlled health services system managed by our tribal professional staff. Our ongoing program planning and management, operating in concert with regional health

systems dynamics, is mandated to provide the best health care available. We feel that our health services better meet community needs now than they did 4 years ago.

The Devils Lake Sioux Tribe has faith in the Congress' intention, specified in the Indian Health Care Improvement Act, to provide the highest possible health status to Indians and to provide existing Indian health services with all resources necessary. Yet, we have encountered serious difficulties in implementing this critical piece of health care legislation. I will attempt to briefly highlight these problems from the tribe's perspective.

The title I health manpower component offers tremendous promise in terms of financing the education of locally qualified Indian students who might otherwise never be able to obtain health services career training, as well as offering the potential for developing providers who will maintain stable, culturally sensitive and long-term relationships with the communities they serve. A major problem of the IHS direct service program is found in the excessive mobility of physicians and related medical personnel. It often seems that job mobility is a factor which attracts professionals to IHS, despite the obvious adverse impact on continuity of care.

Operationally, we have encountered a number of serious problems in the administration of title I. Formulation of the application cycle and distribution of literature have consistently been conducted in an untimely manner. The said scholarship application kits were poorly developed and difficult to complete. Even now, the number of forms, recommendations, transcripts, certifications, and notifications required in submission of an application needlessly confuse and deter propsective students. We have also received reports from various Fort Totten students who have indicated that stipend payments are often late. Most of our students are from low-income families and are unable to sustain their own support until the scholarship payment arrives. Too often, they give up their studies and come home.

The act's, title II, health services has addressed much of the previously unmet health care needs, but continued funding at higher levels would enhance this component's effectiveness.

Title III, supporting construction and renovation of service facilities, remains underfunded for the scope of work necessary. Further, neither IHS administrators nor the act have addressed the construction and renovation of facilities owned by tribes and leased on a long-term basis by the Government. The Fort Totten Health Care Center is a facility of this type.

The title IV component permits Indian beneficiaries of medicare and medicaid electing to use IHS facilities for equality of benefit from these national health programs. It also provides a much needed source of revenue for local IHS program support. The IHS headquarters staff did not, initially, aggressively work to implement the medicaid provisions of this law. In the North Dakota implementation, a contest developed regarding State jurisdictions on the reservation. We must point out that all major judicial precedent reflects the State's obligations to provide equal protection to those living within its geographic boundaries. Simultaneously, the tribal governments have jurisdictional authority on their reservations.

The State of North Dakota has recently ratified an agreement with the IHS for medicaid participation. We are now faced with problems relating to IHS authority to expend these moneys for essential services.

We are told that these funds must be considered nonreserving. They cannot be expended in payroll for essential permanent employees. They cannot be used to increase lease payments to the tribes to permit expansion and renovation of leased IHS facilities. We continue to work with the IHS staff to develop effective improvement in our health program through the use of medicaid reimbursement funds. However, our position would be enhanced if legislation were passed to make IHS participation in medicare and medicaid a permanent source of revenue.

The Devils Lake Sioux Tribal Council and Tribal Health Committee are very concerned about the health problems of urban Indians addressed in title V. If the IHS program were funded at a level which would permit services for urban Indians, even as the reservation communities received the IHS funding necessary for their health programs, the tribe would fully support urban Indian participation. Since, however, the health needs of the reservation continue to receive inadequate support, the Devils Lake Sioux Tribe cannot support the diversion of scarce resources to urban communities in which mainstream health services systems are available. Without IHS on the reservation, we would not have reservation based health services.

The Devils Lake Sioux Tribal Council strongly urges your continued support and financial appropriation for the Indian Health Care Improvement Act. We urge your oversight of the problems discussed in this testimony. We remain optimistic of the benefit of improvement in Indian health offered by the act.

Senator MELCHER. Mr. Ross, you have evidently found that title III, which supports the construction and renovation of the service facilities, has not adequately covered the point of the leasing of specifically the Fort Totten Health Care Center to Indian Health Service; has not been of sufficient amount to provide for adequate renovation; is that it? Did I understand that correctly?

Mr. STRACQUALURSI. May I address that?

Senator MELCHER. Surely.

Mr. STRACQUALURSI. I am Rick Stracqualursi, director of the tribal health program. In fact, the Fort Totten Health Center was built in 1973 with an underenumerated census as its base for size. Since 1973, our number of outpatient visits in the scope of our work, the scope of the outreach services undertaken in our health areas, are such that we have a need, based on the GSA standards, for space of approximately 1,600 additional square feet.

Now, that is a lot of space when we are dealing with—I believe there are only 4,000 net feet available now. The act, as set forth here, at least as it has been implemented, by my understanding, to IHS, provides a mechanism for IHS construction of and/or renovation to facilities of its ownership.

Senator MELCHER. Yes, but not to something they are leasing.

Mr. STRACQUALURSI. That is right. Yet, by the very nature of leasehold over a long period of time, the Fort Totten Health Center is an IHS facility.

Senator MELCHER. If title III were drafted in such a way that would permit the tribe to have a long-term lease, could they use that, then as collateral to add an additional space?

Mr. STRACQUALURSI. Yes, sir. They could.

Senator MELCHER. You would be able to do that?

Mr. STRACQUALURSI. Yes, sir.

Senator MELCHER. Well, you made a good point, and I think that is a point we ought to address in title III at this point. If we are going to reauthorize it, we ought to make improvements. That is a significant point, and we will make note of that and attempt to draft corrections in title III to specifically do what you have outlined here, because it seems to me very essential. You are not going to change anything into an IHS facility; the tribe already owns it?

Mr. STRACQUALURSI. Right.

Senator MELCHER. It makes sense to keep up and keep pace with the needs, and yet there is not anything in title III that adequately covers that unless it should become an IHS facility. That is a very good point. We will try to remedy that.

Now, we are a little confused. First of all, you had a problem with medicaid payments, collecting them, because the State of North Dakota did not think you ought to have them; is that correct?

Mr. STRACQUALURSI. That is correct.

Senator MELCHER. Was that straightened out?

Mr. STRACQUALURSI. Yes, sir.

Senator MELCHER. Do you have medicaid payments now?

Mr. STRACQUALURSI. Yes, sir.

Senator MELCHER. But there seems to be some confusion in the law.

Mr. STRACQUALURSI. Right.

Senator MELCHER. I am quoting:

> Our position would be enhanced if legislation were passed to make IHS participation in medicare and medicaid the permanent source of revenue.

We understand that to be law.

Mr. STRACQUALURSI. Yes, sir. Our State social service board has communicated to Senator Harris on a number of occasions, and to the tribal council and to the State legislature, its posture in feeling that this portion of the law should be amended on the basis that this is a Federal Indian reservation and direct funding is the only appropriate route. When we addressed this issue within the tribal health committee, it was not clear to us how stable and sure title IV would be as a long-term source of IHS support, whether, indeed, we would see a sunset on this particular component in the foreseeable future.

Senator MELCHER. We do not think so, but if there is any likelihood of that, we are glad you brought it to our attention. We do not think that is the case, and we do not think that is the attitude of the appropriation committee in either the House or Senate. But I am glad you made your point because we will be watching for it.

Thank you both very much.

Mr. STRACQUALURSI. Yes, sir.

Senator MELCHER. The next witness is Rick Lucero, director of the Health Department, Montana United Indian Association, Helena, Mont.

STATEMENT OF RICK LUCERO, DIRECTOR, HEALTH DEPARTMENT, MONTANA UNITED INDIAN ASSOCIATION, HELENA, MONT.

Mr. LUCERO. Senator, I represent the Montana United Indian Association, and we are a little different than the presentations you have received today. We represent urban Indian programs in the

State of Montana, of which currently there are eight. They are located in Miles City, Billings, Havre, Great Falls, Helena, Butte, Anaconda, Deer Lodge, and Missoula. In addition to those eight centers, we also have a central office where I am housed that does most of the planning and the grant writing for those eight centers. We also call them Indian alliances because we are a consortium.

I also have the good fortune presently to be sitting as the chairman of the Health Planner's Task Force for the American Indian Health Care Association, which is a national urban association which does most of the presentation for the programs in the country. I mention that by way of indicating that from that vantage point, I have the opportunity to overview the other 33 urban programs in this country and to assess Montana's urban programs in that light. I have also had the opportunity, as the chairman of that committee, to be one of the five authors of the national urban specific health plan that was submitted to Secretary Harris, and in doing that, I also had access to a numerous amount of data.

One of the striking things that I was made aware of in the process of doing the specific plan, the national draft, was that between 40 to 50 percent of the Indian population in the United States at any given time is living off the reservation and in an urban area at one time or another, and that is particularly interesting in light of the fact that the majority of the funding that is allocated right now for Indian programing goes to the reservations, when, actually probably 40 to 50 percent of the population at any given time is living in an urban area that has only $8 million nationally for health care for the urban populations.

That is particularly significant when you talk about Montana. You are talking about an urban area that is comparable to, say, Portland or Dallas. Our population numbers, approximately, anywhere from 14,000 to 20,000 urban, or we prefer the term "off reservation," Indian people in the cities at any given period of time. Those people have the unique problem in this State—because of its vastness and mileage and because of the severe winters—of not being able to get access to the reservations as frequently or as often as necessary to receive the health care.

Many of our urban Indian people are tribally enrolled and, therefore, they are eligible for some of the health care that is provided on the reservations. The major problem we have encountered there is that the reservations are underfunded themselves so that when they set their priorities for the tribal people who are living on the reservation, oftentimes we find our urban Indian population having to wait significant periods of time so that they can receive the care that they need.

The other uniqueness, I think, of the urban Indian program in this State is that we do not have sovereignty in the sense that the tribal programs do. We must have access to the current human resources that are available in each of those localities, so we must work with the State and local and Federal people in the encumbering of services for the urban population. Our concern there, however, is that Montana is still somewhat provincial in its attitudes, and therefore access to health care for the urban Indian is sometimes very difficult because of discriminatory practices or because of lack of experience on the part of the providers in being sensitive and aware of the cultural differences.

In 1979, the approximate funding for the 41 urban programs was $8 million. Of that amount, the State of Montana received $365,000 specifically for health care for the urban populations. If you divide that by eight urban cities, you can see that it is very difficult for us to do more than a bare minimum service, medical care and services for the Indian population, with small amounts of money.

In the testimony that I have submitted to you, there are some figures that indicate what dollars we have in each of those eight alliances and the kinds of services that are being provided right now. The concern that we have is that last year, we were mandated by Public Law 94-437 to develop a specific urban health program for 40 programs, and that was to go to Secretary Harris. At that time, we had to use a resource allocation formula that was mandated by IHS to calculate the unmet health need for the Indian populations. It is obvious, living right now as we are with inflation the way it is, that there is no way in reality that we can expect to receive the $5 million—almost $6 million that was calculated for the State of Montana for its urban programs in 1981.

What we would like to do, however, is recommend that you consider strongly and support the amount of $500,000 for the next fiscal year, and that will help us to get some of the programs on the road. Our major problem is that we have been studying the urban Indians' unmet health problem in the State of Montana for the past 5 years. People working in this area know what the need is. What we need now are dollars to address that need in a way that is comprehensive, that is sophisticated, and that is professional. We cannot do that when we are limping along on a shoestring budget.

We have four alliances right now that are offering some measure of direct care. Of those four alliances, two of them are offering less than $3,000 of direct care a year. Populations are needing much more services than that.

I want to speak again to the reservation situation. We are urban programs, and we are under title V of Public Law 94-437. If it were not presently for the cooperative relationships that the Montana United Indian Association has developed and established with those reservations, the urban Indian population in Montana right now would not be receiving health care at all. So it is very important that when you consider this particular law, that an attempt be made to fund and authorize the full funding for Public Law 94-437 for the tribes because we are dependent upon their resources, also.

I would like to make one other comment that I was not prepared to make, but in listening to the other group talk about alcoholism, I would like to recommend to you, Senator, that one of the problems with alcoholism services in this country right now is that we are still providing that service clinically, based on research and theories and treatment modalities that were basically developed for a nonminority culture, and I submit to you—I have worked in the field for 12 years both as a clinician and as a program developer—that what needs to be done at this point is that some sort of research needs to be done, a research and demonstration grant needs to be developed wherein the historic research that has been done on Indian alcoholism is researched very thoroughly and the implications of that research is put down into some kind of a program where training can be provided based on that.

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The fact that we have culturally specific Indian alcohol programs right now is a good first step in that area, but it is only half of the effort that needs to be made. It is important that we have people indigenous to our area that know the culture and can speak to the people and relate to them.

The other half of that has to be some skillful grounding and professional treatment modalities, and I would submit again that the basic treatment modalities that are used right now are not feasible. So what you have when you train an Indian alcoholic in a non-Indian treatment setting—and that is essentially what you have in this country—you end up or have half or three-quarters of a counselor. We need to develop new methods, research those, and we need to look into the research that is being done and make proper application of that research in the development of treatment service for the Indian alcoholic.

In Montana, as was mentioned earlier, the major health problem is alcoholism, and as long as it is rampant as it is in this State, the other emphasis to lower or raise the health index will be short circuited because as long as there is alcoholism in the family, you are going to continue to run into problems of economics, social discrimination, and other things that are attendant with alcoholism and low health care.

So I would like to recommend to you that you consider supporting the authorization of 94–437, in this instance, title V, so that we can get on with the business of building the kind of health programing for the urban Indian, so that we can raise their health care level to that of the rest of the United States' population.

Thank you.

Senator MELCHER. In your receipts of funding other than from title V, what are you getting in addition?

Mr. LUCERO. For health care, that is essentially it right now with the exception of a mental health grant that was awarded to the organization by the National Institute of Mental Health last August. Currently, those two programs, however, are running separate. The mental health program is a research and development program, not really a direct services program at this point.

Senator MELCHER. Has there been any participation from the State?

Mr. LUCERO. To the extent that they are being contracted with to provide some of the supervision to the cultural specialists, as we call them, in our center. However, that poses the problem I just alluded to with regard to their being trained in a nonminority setting, and we have found that to be ineffective. At least, I have found it to be so in my research and experience.

Senator MELCHER. Are you still phase II, or have you moved to phase III?

Mr. LUCERO. We have two programs in phase III: Great Falls and Billings here. We have another program ready in Helena that is phase III. The only thing stopping us from getting into outpatient medical care there is lack of funds. Missoula is also ready for phase III outpatient medical services.

Senator MELCHER. Your 1980 appropriation is about $393,000?

Mr. LUCERO. Yes, $398,000 is anticipated.

Senator MELCHER. And that is from title V?

Mr. LUCERO. Yes, sir. We have been limited in our opportunity to use that money for direct care, however, by IHS. It is their feeling that other studies and other preparations need to take place first, and, like I say, we have studied the problem to death. We are ready to provide the service.

I would also like to comment on something Kevin Howlett said earlier. We need to pump some money into prevention. That is one of the ways to become cost effective and reduce the amount of dollars that we need from you.

Senator MELCHER. I certainly agree.

Thank you, very much. The material you submitted will be included in the record at this point.

[The material follows:]

MONTANA UNITED INDIAN ASSOCIATION,
Helena, Mont., March 26, 1980.

TESTIMONY OF EDDIE BARBEAU, BOARD CHAIRMAN, MONTANA UNITED INDIAN ASSOCIATION

The Montana United Indian Association (M.U.I.A.) is a non-profit, tax-exempt consortium providing human and social service assistance to Native Americans residing in eight Urban areas in the State of Montana. The M.U.I.A. Health Department currently receives funding through Indian Health Service under Public Law 94-437 Title V Appropriations. It is to this purpose the following testimony is being presented to justify the need for continued and expanded funding authorization of Public Law 94-437.

The Montana United Indian Association, through 94-437 Title V funding, has made several significant gains in improving health care for the Native American living in the Urban areas of Montana.

During the past fiscal year direct health services have been made available for clients in need of medical assistance in Billings, Great Falls, Helena, Missoula and Anaconda. The Great Falls Center currently employs a full-time registered nurse to provide medical screenings, counseling, education and referrals to doctors contracted with in the Great Falls community. The Billings Center receives eight hours of full clinic services per week contracted through the Yellowstone City-County Health Department.

At present the Missoula and Helena area Indian populations (1,500 and 2,323 respectively) warrant the health need and administrative preparedness to develop part time clinic operations when funding is available. With a 15 percent increase in M.U.I.A. Health funding these two centers would be able to contract with a part time physician and registered nurse to provide medical services.

In the present fiscal year only $6,309 has been contracted to provide medical services in the three areas of Helena, Missoula, and Anaconda. Considering a Native American population of 4,293 residents in these areas with a 62 percent utilization rate (2,662 clients) the amount available for medical, optometric, dental and pharmaceutical needs is less than $2.40 per client. Due to these limited amounts only about 9 percent of the population in need can be served. The Havre, Butte and Miles City Alliances currently have no direct or contract services available through present allocations. Though every effort is made to coordinate with existing healthy facilities and receive volunteer medical services, the limited dollars to provide personnel for advocacy, transportation and referral place a marked barrier between the Indian client and the local medical facilities.

Throughout the State the trend toward off-reservation migration has continued at a steady pace with the Indian Self-Determination to: 1) maintain his pride and dignity, 2) develop the skills and educational background necessary to support his family in off-reservation life. In order to accomplish each of these tasks it is first necessary to have sound physical and mental health care available at a reasonable cost. Not only do these services need to be available; but there is also a need for advocacy and assistance in making these services accessible to the Indian client.

At this time there are more than 12,000 Indians documented living in the eight Urban areas which provide health care through the Montana United Indian Association. Over the past three fiscal years, though 437—Title V funds have been

increased, fiscal year 78, $342,000, fiscal year 79, $369,000, fiscal year 80, $398,000), they have increased at a rate of less than 10 percent per year. Considering the increases in medical care and the increasing population, this amount of funding does little to bring the Indian client health care to parity with the United States average.

In fiscal year 80 the Billings Indian Center Clinic is operating at above maximum capacity on a budget of $74,621. In order to provide additional clinic hours and transportation services a minimum M.U.I.A. funding increase of 7 percent is necessary to service their Indian clientele. Through cooperative agreements with the Crow Agency the Billings Center is provided good medical and pharmaceutical services when weather does not bar access due to the treacherous 110 mile round trip. However, medical needs cannot be tempered by weather nor can the Crow Agency be asked to continue serving off-reservation clients when they are understaffed and face funding deficits to serve their own-reservation people.

This brings to point the need to assess the 437 Title V appropriations and the availability of direct care and Contract care service dollars being funneled into Urban programs in Montana. Through funding specifically earmarked for medical services, in accordance with the Urban Specific Health Plan, the Urban Indian Population will benefit as will the Communities in which they live through providing overall better health in the schools and employment systems.

According to the Resource Allocation Criteria used in the Urban Specific Health Plan funding for Montana Urban Programs in the amount of $5,941,862 would provide a comprehensive health care delivery system in 1981. We realize the austere federal budget at this time yet sufficient Urban Indian Health Care should be assessed as a priority program by the Federal Government. Until such time as it is, the ill-health of the unemployed Urban Native American will continue along with the generational cycle of poverty and loss of human potential. Present data on economic, educational, and social status of Montana's Urban Indian population show that the majority live in economically depressed neighborhoods, have a low educational level, a high drop-out rate, a high unemployment rate and suffer from the negative influences of prejudice in the Urban setting. In many cases all the above conditions relate to the poor physical and/or mental health status of the Urban Native American.

Public Law 94–437, the Indian Health Care Improvement Act, contains the congressional intent to bring the health status of American Indians and Alaskan Natives up to the level of the rest of the American population within the seven year span of the act. Unless Title V is reauthorized by Congress at a suitable allocation level the low Indian utilization of health services will not be overcome.

The Montana United Indian Association recommends an allocation of Title V programs for their eight Urban centers in the amount of $500,000 as compared with the Resource Allocation Criteria formula of more than 5 million.

The reauthorization of funding of Title V of 94–437 will allow the continuation of the successful and important strides made by the existing 41 Urban Indian Programs in raising the level of health for the Indian Population who otherwise could not afford adequate health care services. In addition, it would provide for comprehensive health care in a manner that is consistent with accepted standards of quality and continuity of those services.

The Montana United Indian Association Title V of Public Law 94–437 authorizations as follows: 1981—$27,764,000; 1982—$27,744,000; 1983—$27,727,000; 1984—$27,727,000.

We request your support for these appropriations and authorization to continue Title V funding during fiscal years 1981 through 1984.

Senator MELCHER. Our next witness is Allen Rowland, president of the Northern Cheyenne Tribe, Lame Deer, Mont.

STATEMENT OF ALLEN ROWLAND, PRESIDENT, NORTHERN CHEYENNE TRIBE, ACCOMPANIED BY TOM GARDNER, TRIBAL HEALTH DIRECTOR

Mr. ROWLAND. Thank you. Mr. Chairman, I appreciate the opportunity to present our paper here this afternoon. The gentleman up here with me is Mr. Tom Gardner, our tribal health director, and he will go ahead and read this. If there are any questions later, we will both try to answer them.

Senator MELCHER. Please proceed.

Mr. GARDNER. Mr. Chairman, this testimony is on behalf of the Northern Cheyenne Tribe and the Northern Cheyenne Board of Health. The responsibilities we have to our people prompt us to express some of our concerns on Indian Health Service. We maintain the maximum tribal participation in the decisionmaking processes regarding the Indian Health Service administration of health-related services and to advocate tribal interests relative to the national policy of tribal self-determination. Like other tribes here today, we would prefer that it would have been unnecessary to burden this committee with our problems, but since the Indian Health Service has chosen not to provide an adequate forum to address our concerns, we appreciate this opportunity to express our views even as we recognize the calculated risks involved.

We trust that this committee will give serious attention to the problems and concerns presented here today and that a positive effort will be initiated to assure maximum utilization of Federal dollars which are beneficial to both tribal constituencies and the service, and that Members of Congress will rest assured of the successful implementation of its program activities.

We would like to address the committee on Indian Health Service opinion, see attached exhibit A, in regards to area office regulations in memorandum of agreements for Public Law 86–121 projects.

Senator MELCHER. We will make that a part of the record at the end of your testimony.

Mr. GARDNER. Thank you.

Under the circumstances, it would be reasonable to assume that tribal governments have been consulted rather than given a directive, and that these opinons were made for the convenience of IHS. Mr. Chairman, that is the attachment that we want to address, but let me continue. Then, we will get back to this question as I get through reading the remainder of the testimony.

The Public Law 94–437 and its titles have not been really taken advantage of by our people on the Northern Cheyenne Reservation. The information on developing a tribal specific health plan was a short notice. So specifically designating a reliable and complete health plan requires enough time to do a good job. The result is that many of the plans may not reflect an accurate assessment of health service needs and therefore may not have desired credibility to justify authorizations commensurate to real needs. We believe that there should be supplemental and modification plans added on to these plans.

We are just now becoming aware of Public Law 94–437 and the intent and its potential status goals to improve health care for our people. We desired to be assured that successful implementation of congressional mandated legislated goals of health concerns and tribal self-determination become a reality. We request that Public Law 94–437 be extended and reauthorized.

In recent years, Congress has, in its wisdom, enacted exciting and constructive legislation which provides the wide range of options and opportunities unparalleled in the history of Federal and Indian relationships.

Our own appreciations and enthusiasm for exercising such opportunities is dampened only by the failure of the bureaucracy to act in good faith.

Following are our recommendations, clarifications, and standardizations of the following definitions from the Indian Health Service: No. 1, direct services; No. 2, contract services; on or near regulations imposed by IHS; establish clearly defined performance standards for all administrative levels of Indian Health Service; and No. 3, the last but not the least, is to establish a joint performance monitoring mechanism between Indian Health Service and Indian tribes and require reports for annual congressional review.

Mr. Chairman, the question that we are addressing in the attachment—this is an in-house regulation, IHS in-house regulation—is pertaining to Public Law 86–121 projects. That exhibit has two parts, and the question that hopefully will be clarified in the near future is that, at any time, if in-house regulations can be imposed upon the tribe, there should be a meeting of minds since this Federal agency is entrusted with the congressional mandates and they are the providers of the Indian health service delivery system. We are put in the position, too, as the consumers of those health services, that we should help implement policy to determine a quality of services that we are receiving. So in this exhibit, we feel that we should have been consulted when this regulation was made.

Senator MELCHER. In regard to this attachment, exhibit A, dated March 7, 1980, regarding the area sanitation facilities construction officer, Billings area, Indian Health Service, memorandum of agreement provisions, we will consult with Indian Health Service on the need and necessity for those two paragraphs that are almost automatically, under this memorandum, included in the agreements. We are not presently certain that this is required under law, but we suspect it is. If Indian Health Service found it was, this may not be something that they had any discretion over. But we will check it out, and we will get back to you on it.

Mr. ROWLAND. Going back to the same thing Mr. Gardner was discussing here, the way the law reads, it says that they will come up with money for funding for maintenance and operations, and that is where our hang-ups are right now. We would be more than happy to operate Indian Health Service facilities on the reservation, provided that they give us money, and that is what this thing is all about. They never furnish enough money. They do not furnish any for us to maintain our programs, and that is all that we are asking.

Senator MELCHER. And they are required to do it.

Mr. ROWLAND. Yes, sir.

Senator MELCHER. I take it that there are two things lacking so far in the tribe's utilization of Public Law 94–437. One is technical assistance; is that right, Allen?

Mr. ROWLAND. Yes, sir.

Senator MELCHER. And you really haven't had sufficient technical assistance from the area office?

Mr. ROWLAND. No, sir.

Senator MELCHER. Also, if I read your testimony correctly, I do not think you had adequate notice. There was too short a time between the time you were notified under Public Law 437 and the time you should get your study in and get it completed, and you simply did not have adequate time?

Mr. GARDNER. No, sir.

Senator MELCHER. When did you receive notice?

Mr. GARDNER. I just got on board as the tribal health director in July last year, and they had their notice probably 2-months prior, probably in April.

Senator MELCHER. Well, that is not very much time to develop one of those. Is the first plan for 1 year that you are expected to provide?

Mr. GARDNER. Yes, sir.

Senator MELCHER. Then, the next one is for 4 years; is that correct?

Mr. GARDNER. Right.

Senator MELCHER. Thank you very much.

[The exhibit follows:]

EXHIBIT A

March 7, 1980.

Through: Assistant Area Director, Environmental Health and Engineering Programs

To: Area Sanitation Facilities Construction Officer, Billings Area Indian Health Service

MEMORANDUM OF AGREEMENT PROVISIONS

The following two paragraphs should be included in all future Memorandum of Agreements for P.L. 86–121 projects:

1. That the Tribe has reviewed the provisions of the attached Project Summary and concurs in its contents and recommendations.

2. That upon completion of construction and testing of the facilities as outlined in the attached Project Summary, the Indian Health Service will place the facilities in an inoperable condition until such time as the Tribe accepts transfer of the facilities as evidenced by the signing of a Transfer Agreement.

GEORGE L. ALLEN, P.E.

Senator MELCHER. Jessie, were you going to testify again?

Ms. JAMES. Yes sir.

STATEMENT OF JESSIE JAMES, VICE CHAIRMAN, MONTANA INDIAN HEALTH BOARD, ACCOMPANIED BY JOLENE BEAUMONT, COUNSELOR

Ms. JAMES. My name is Jessie James, and I am up here now as vice chairman of the Montana Indian Health Board and to talk about the continuation of funds for the 437, especially with the title I section.

You asked a question of Dr. Lois Steel, something to the effect of how much additional funds that they need, and am I correct, did I hear you right, that there is only one-half million dollars for title I?

Senator MELCHER. For 1980, it was a little over $11 million authorized.

Ms. JAMES. How much?

Senator MELCHER. $11 million, a little more.

Ms. JAMES. OK, $11 million. I was going to say that is really terrible.

When I did my internship was the first time I ever met Dr. Lois Steel, and I did my internship with the Student American Medical Association in 1973. For 5 years, I worked as a counselor. There were very few Indian students going into the medical fields at that time, medical field studies. Also that was the first time I had ever heard of the INMED program.

I think it is a very fine program, and that is the kind of college which we are talking about here. What we are talking about here for the 437 title I program is a base thing of working with the Indian students at the local level.

At the present time, the title I program, under the Montana Indian Health Board, is funded at approximately $66,219. Now, we would

like to get that so that it meets more of the needs of the reservations' students and also to expand that about 70 percent which would mean requested additional funds totaling $150,000.

I have with me Jolene Beaumont, and she is a counselor. I do not think there is anybody better qualified to talk about working with Indian students or their needs, or that can refine the support for a program and stress to you the importance, than a counselor that has done that work. I would like to turn it over to Jolene and have her talk to you.

Ms. BEAUMONT. Right now, the 437 program is on the project of trying to make the grades K through 12 aware of health professional fields. In the past, this need has never been met, and now that we have this funding to do that, we are meeting some hardships out in the field, that it should be an ongoing thing and that if we had counselors out on each reservation doing this on a continuous basis instead of us visiting the reservation once a year, I think bigger steps would be going toward success for the program.

At present, we have a lot of students on each reservation. I think the statistics are—on the schools that we cover in your proposal there—there are 75 schools that we have to cover, and there are 8,318 students that we have to meet, and if we do have representatives on each reservation, I believe we can make a better coverage on these students. Some of the hardships that the students face on each reservation is that the teachers are sometimes unqualified teachers due to the isolation of the towns that are located on each reservation. The 437 program can work with each school that is located on the reservation so that they can help these students become aware of professions that they may enter.

The science and the math can be better met. On some of the reservations, the students still speak their native language, and it takes a while for them to adjust to the English language. Things like this. On the local level, it can be handled on a better basis.

Ms. JAMES. One of the problems, too, on reservations, and in smaller schools, is the lack of adequate mathematic and science programs. I think there is a great deal of attempt to remedy the situations on the majority of the reservations, but we still have a problem. Our kids are not geared to thinking of themselves as being doctors. Medicine men, yes, but doctors? There has been a separation there someplace. That is something that we have to work at as Indians with the help of programs like this.

Senator MELCHER. I think you will find there is not much difficulty with mathematics. I think it is the lack of attention to it, whether they are Indian or non-Indian. I think it can be remedied.

From what you have said, there is one individual that is available now for all of the schools?

Ms. BEAUMONT. Right now, there are three people. Two staff members, two of us are counselors, and we have one secretary working with eight reservations, and altogether, 75 schools.

Senator MELCHER. I looked through the list here. There are eight reservations in Montana and Wyoming, 8,000 students, and 75 schools, and there are only two counselors?

Ms. BEAUMONT. Yes, sir.

Senator MELCHER. So what you are really doing is visiting one or two schools a week; is that it?

Ms. BEAUMONT. We are going to each reservation, as you see the schools listed in there. We are taking 1 week out of the year to visit all of the schools on each reservation.

Senator MELCHER. So you are on the Northern Cheyenne, and you have 10 or 12 schools. That means you visit one in the morning and one in the afternoon during that week, and you only get there once a year?

Ms. BEAUMONT. Yes, sir, the way the proposal is made principally, and the way the funds are available, too, that is all we can do. What we have to do is get a component in there to work with the school systems. The only way we can meet the other parts of the objectives is that we communicate on a letter basis or telephone basis, and it is an ongoing thing. There is a demand. We want to have our kids aware that they can be professionals. There are a lot of things that they face on the reservation. They face prejudice. Sometimes they have a fe. r in them they have to overcome, and if they can do good in school, maybe they can overcome it outside the school systems.

Ms. JAMES. I believe INMED did a study a number of years ago, and it showed that Indian children—I believe it was up to the fourth grade—have natural ability for math and sciences, but through the present or non-Indian influenced school systems, it kind of was knocked out of them. They were taught that they really are not that smart. That was one study that really interested me because I saw the reality of it.

Senator MELCHER. We notice that the funding for this part—it is section 102 of title I—remained constant from 1978, which really means it hasn't kept up at all. Same level appropriation in 1978, same in 1979, same in 1980, I take it; is that correct? Still just $900,000 for section 102?

Ms. JAMES. Yes, sir, that is a continuation. I don't know what section you are looking at.

Ms. BEAUMONT. I don't, either. Presently, we went on board in November—the staff went on board and was given this awareness proposal to meet, and that was the time that the board started utilizing awareness programs.

Senator MELCHER. Thank you both very much. I am glad you brought this to our attention. It looks like a very promising part of the act, providing we have sufficient funds to make it meaningful.

Ms. JAMES. May I ask you one more thing? Did you want a copy of the material that we had for the Fort Belknap Hospital, or may I send it to you?

Senator MELCHER. Yes, I wish to announce to everyone that the hearing record will remain open for 3 weeks, and we would be pleased to have any additional information or data that you can furnish us.

Ms. JAMES. Thank you.

Senator MELCHER. That completes our witnesses for today. The hearing is adjourned.

[Whereupon, the hearing was adjourned at 3:50 p.m.]

ADDITIONAL STATEMENTS RECEIVED FOR THE RECORD

PREPARED STATEMENT OF THE ARAPAHOE TRIBE OF THE WIND RIVER RESERVATION, WYOMING

Mr. Chairman: As Chairman of the Business Council of the Arapahoe Tribe of the Wind River Indian Reservation, Wyoming, I am grateful for the opportunity to present the Tribe's views on the Indian Health Service in connection with your Committee's oversight hearings.

This statement represents the views of the Arapahoe Business Council on the problems facing our people in the area of health care delivery. I request that this statement be entered into the record for this Committee's oversight hearings on the Indian Health Service.

The Wind River Reservation comprises approximately 3,500 square miles in two counties in west central Wyoming. Approximately 5,300 Indian people, residing within these two counties, utilize the health services furnished on the Wind River Reservation.

Two health centers are operated by the Indian Health Service on the Reservation. They provide outpatient medical and dental services, as well as community health nursing, mental health, health education, environmental health, and social services. Inpatient health care and specialty medical services are made available through the contract health services program by way of contractual arrangements with hospitals and physicians.

Although the health care furnished by the Indian Health Service meets many of our needs, we continue to face problems that prevent our people from receiving complete, satisfactory medical care. First, we believe that Indian Health Service funds within the Billings Area are not being fairly distributed among the Service Units. As a result, we do not have sufficient funds particularly for contract health services. Second, our people must travel over 1,000 miles to Seattle, Washington, to obtain in-hospital treatment. Third, because of bureaucratic red tape, persons in need of emergency medical care are being turned away from the hospitals in Riverton and Lander—and cannot get essential immediate medical treatment. The remainder of this statement will elaborate on these problems, which we commend to the Committee's attention.

ALLOCATION OF FUNDS

We believe that the Wind River Reservation is not receiving a fair share of the available contract health services funds in the Billings Area, primarily because the allocation formula used to distribute funds does not take into account all the revelant factors that determine each Service Unit's needs.

The contract health services program is designed as a secondary resource for Indian people. According to the regulations for this program, the Indian Health Service may not authorize use of contract services unless an individual Indian does not have alternate (primary) resources available to him. In particular, Indians who are eligible for Medicare and Medicaid may not use contract health services if these federal programs pay for the medical care. Therefore, Service Units in which a greater percentage of Indians are eligible for Medicare and Medicaid, a primary resource, actually need less funding for contract health services, a secondary resource. Despite that fact, the Billings Area does dot factor the percentage of Indians eligible for Medicare and Medicaid in each Service Unit into its distribution formula.

Our people are being shortchanged by this improper allocation method employed by the Billings Area Office. Only about 3 percent of the Indians on the Wind River Reservation are eligibile for Medicare and Medicaid. In contrast, about 30 percent of all Indians in Service Units in Montana are eligible for these services. These figures indicate that we have a greater need for the contract health services than Montana Service Units, a need that is simply not being met.

This inequity in funding allocation is well-illustrated by a comparison between the fiscal year 1979 funding levels at the Fort Peck Reservation in Montana and at the Wind River Reservation. The two Reservations are approximately equal

p. 102 blank

in population, but the cost of a hospital visit at Wind River is $325/day, 40 percent more than the $229/day at Fort Peck. In addition, approximately 30 percent of the Indians at Fort Peck are eligible for Medicare and Medicaid, compared to the 3 percent at Wind River. Despite this, the Billings Area allocated only 26 percent more in funds to Wind River than to Fort Peck—$2,110,000 to Wind River, and $1,675,000 to Fort Peck. As a result, we were forced to ask Congress for a special additional appropriation to bolster our seriously underfunded programs. And again, in the first quarter of fiscal year 1980, the pattern is being repeated; our contract health services program already is operating at a deficit.

The Billings Area Office maintains that it cannot adjust its allocation formula to take Medicare and Medicaid elibigility into account because it cannot obtain accurate data. There are, however, computer printouts available which list all persons within a state who are eligible for Medicare and Medicaid. We believe it is imperative that the Area Office develop figures from these printouts, or some other source, to take these factors into account, so that the present inequitable distribution of funds can be remedied.

DISTANCE TO HOSPITALIZATION FACILITIES

When our people need major inpatient hospital care, the Indian Health Service sends them to the Public Health Hospital in Seattle, Washington, over 1,000 miles away from the Wind River Reservation. Adequate hospitals, which can provide the same services, are only 30 miles away in Riverton and Lander.

Sending individuals such a great distance for major medical treatment exacts high social costs among our people. It disrupts our families, with much time and money wasted in transportation alone, and makes it virtually impossible for family and friends to visit the individual during the critical period of hospitalization. It is unheard of among any other group in America for individuals to travel so far for hospital care, other than for unusual specialized treatment.

Although we recognize that the Indian Health Service has a master agreement with Public Health Hospitals around the country, whereby these hospitals provide care to eligible Indians, we feel that the agreement should be changed, or an exception to the agreement be made, when the closest Public Health Hospital is over 1,000 miles away. Arrangements should be made with some of the fine hospitals in Riverton and Lander so that our people will not pay such high social costs for hospital care.

AVAILABILITY OF EMERGENCY MEDICAL TREATMENT

In order for individuals to obtain emergency treatment, they must either go to one of the health centers on the Wind River Reservation or get specific authorization from the health center for treatment at a local hopsital. However, Indians who need immediate treatment often cannot get to the health centers, either because they are too far away (Riverton, for example, is 30 miles from the health centers) or because the health center is closed for the night or the weekend. As a result, they go directly to the nearest hospital—where many have been turned away because they do not have authorization from the health center.

In one instance, an Indian woman living in Riverton tried to get treatment one night at the Riverton Hospital for a broken leg. The hospital refused to treat her until she had authorization from the health center; consequently, she was forced to wait overnight at her home, untreated, until the following day when the health center opened for business, before she received authorization for the essential care.

We find it appalling that an individual should be caught in this bureaucratic dilemma when he needs immediate medical attention. At the least, the Indian Health Service should work out an arrangement with nearby hospitals whereby the hospitals would accept Indian patients on an emergency basis. And, in general, health care delivery would be improved if there were less red tape interfering with the delivery of health services to Indians at the Wind River Reservation.

On behalf of the Arapahoe Tribe, I appreciate the opportunity to present this statement for the record. If you should have any questions concerning these issues, please contact me directly or our Washington, D.C. attorneys at Wilkinson, Cragun & Barker, particularly Sue Berghoef, Tony Rogers or Glen Wilkinson (833–9800; as of April 18, 1980, 783–4800).

Respectfully,

JOSEPH OLDMAN,
Chairman, Business Council,
Arapahoe Tribe of the Wind River Reservation.

PREPARED STATEMENT OF THE NATIONAL URBAN INDIAN COUNCIL

Mr. Chairman, members of the committee and staff, my name is Gregory W. Frazier, and today I am pleased to present testimony on behalf of the National Urban Indian Council regarding the urban specific health plan portion of the national plan, prepared by the Indian Health Service in fulfillment of the requirement of section 701 of Public Law 94-437 entitled, the Indian Health Care Improvement Act.

The National Urban Indian Council is a national community based organization with in excess of 100 affiliates from urban areas throughout the United States. Since passage of the American Indian Health Care Improvement Act, the Council has been seriously concerned with the efforts of the Indian Health Service in its endeavors to prepare a national plan. This can be illustrated by the attached correspondence. Document No. 1 is a letter of October 2, 1978, in which the Council requested some basic information from I.H.S. regarding urban Indian health activities. Document No. 2 from NUIC to the Aberdeen area office of I.H.S. is in regards to information the Council received concerning activities of I.H.S., headquarters relative to title V of Public Law 437. Please note that this was the first information received by NUIC, and further, I.H.S. headquarters had supposedly been communicating with "Urban Indian Groups" for some time, but had ignored the largest national urban Indian organization in the United States. Document No. 3 reflects NUIC's interest in receiving further information from I.H.S. headquarters. Document No. 4 volunteers NUIC to I.H.S. in their Public Law 437 efforts. Document No. 5 is I.H.S.'s official response which states that they would place the Council on their mailing lists, however, as a result of the positive progression of their efforts NUIC's assistance would not be needed. Throughout this period of time, the Indian Health Service repeatedly assured NUIC that the urban Indian population would, in fact, be widely consulted with, and adequately accounted for in the Indian Health Service's efforts to secure data for inclusion in the national plan.

These assurances included responses by I.H.S. that urban organizations had been notified, even if they were not recipients of I.H.S. funds under title V, and that they would develop a "general summary" report to be submitted to the Indian Health Service area/program office nearest to the local Indian Community. However, outside of the 41 I.H.S. urban contractors, few Indian organizations had the financial capability to prepare these rather extensive plans, nor could their limited resources allow them to travel as extensively as the urban contractors. Additionally, the quality of technical assistance that was to be available from the Indian Health Service, to both urban Indian contractors and non I.H.S. contractors, was extremely poor, and its availability questionable. Moving on to document No. 6, a memo dated November 2, 1978 from Dr. Johnson to area offices, this document supports our contention delineated above, and admits that as of that date there existed what he refers to as, "some confusion" relative to urban specific health plans, further, the memo indicates that I.H.S. policy is not to provide assistance to urban groups outside of their 41 contractors, which would appear contrary to the law itself. Subsequently, the situation existed were non I.H.S. contractors were excluded during the development stages of the urban specific health plan, and most importantly, they were, in fact, not in a position to prepare a general summary. I.H.S.'s position that urban Indian organizations were able to submit a general summary exemplifies a gross incompetency on the part of this Federal agency and its staff, or inexcusable ignorance.

On February 15, 1979, board members of the National Urban Indian Council met with Dr. Emery Johnson and Dr. Robert Birch, and expressed their concerns that many of the urban Indian organizations localized needs would not be included in the urban specific health plan (document No. 7). The National Urban Indian Council, again, volunteered to work in conjunction with the Indian Health Service to arrive at some factors, (i.e., population statistics, minimum income levels, unemployment level, etc.) throughout the United States, so that the Indian Health Service could reflect a statistically valid statement of need.

Dr. Johnson's initial response to these issues was that the National Urban Indian Council should not concern itself with non urban Indian health contractors being accounted for in IHS's plan, and assured us that the area offices of the Indian Health Service would take into consideration that population. When required by representatives of the Urban Council during the meeting as to the realism of that expectation, Dr. Johnson admitted that realistically there would be a high probability of error in the provision of that information by the area offices. Both Dr.

Johnson and Dr. Birch then agreed that a possible mechanism that the Indian Health Service could utilize to arrive at factors for extrapolation of statistical data could, in fact, be arrived at through efforts by the National Urban Indian Council. The council responded to this that they would be very pleased to provide such assistance. Dr. Johnson indicated that a staff person, Wes Halsey, of the Indian Health Service would work with staff of the National Urban Indian Council to arrive at designated statistical factors which would be desirous to all parties concerned.

When time began to run short according to timetables specified by Dr. Johnson NUIC officials, and staff of the Indian Health Service had yet to contact the staff of NUIC, the Council took the initiative, and attempted to contact the staff of the Indian Health Service. Document No. 8 vividly illustrates the frustrating responses that NUIC received from staff of the Indian Health Service concerning its inquiries as well as a total lack of cooperation on the part of IHS. Finally, in response to our efforts, NUIC received from Mr. Halsey, IHS staff person designated by Dr. Johnson to assist the Council, document No. 9. The committee will please note that the information submitted by Mr. Halsey to the Urban Indian Council, this single document acquired at great expense, was totally irrelevant, and in fact, concerned a topic totally unrelated to what the Urban Council was requesting, and that this single document was acquired at great expense. The final correspondence that I will submit to you today, document No. 10 summarizes NUIC's position of March 20, 1979. At this time NUIC came to the conclusion that, as a result of repeated IHS resistance, negativity and unresponsiveness it could not provide appropriate information in a timely manner. NUIC then decided to monitor IHS—Urban specific health plan effort, and to report to the Senate Select Committee on its observations. This involved a close monitoring activity of the process which the urban contractors of IHS went through to arrive at figures presented to Congress.

IHS had planners from some of the 41 urban Indian health projects travel to Denver, Milwaukee, Rockville, Santa Fe and Minneapolis. These planners would arrive at valid statistical figures, then with what could only be described as being arbitrary IHS would change those figures, without justification the IHS in its report to Congress on the unmet health needs of urban Indians in the urban specific health plan did not reflect those actual documented figures. Further, the IHS request for fiscal year 1981 which was based on documented need, would have been $99,572,000, but was rather a mere $8,000,000. (See chart below).

	Actual need	IHS/USHP	IHS budget request
Fiscal year:			
1981	$99, 572, 000	$27, 764, 000	$8, 000, 000
1982	106, 990, 000	27, 794, 000	NA
1983	115, 349, 000	27, 727, 000	NA
1984	123, 804, 000	27, 727, 000	NA

There obviously exists a considerable disparity between what is needed to alleviate a recognized and statistically supported problem and what has been asked by IHS for the coming year. We have been advised that IHS has submitted these inaccurate figures as a result of its belief that Congress would find the lesser figures more acceptable than the real statement figures. Presently, some of the urban health planning people who have been in the process of compiling the statistics for verification of unmet health needs are frustrated, and have taken the position that they want very little to do with the figures presented by IHS. These planners, as does NUIC, questions both the validity and reliability of these statistics. IHS has also made the gross error to assume that the 41 urban contractors represent 50 percent of the off-reservation population, and therefore doubled that figure to arrive at a statement of IHS's financial needs to service the off reservation Indians in the United States. A third grader taking basic math could have arrived at a better mathematical system. The system used by IHS is so bad that they have changed it numerous times during the ongoing process. Presently, IHS is using the tribal R.A.C. which is obviously unrelated to the urban Indian population. The most glaring faults were brought to the attention of IHS in meetings in Rockville and Sante Fe, however, IHS has failed to take any corrective action.

In 1977 representatives from throughout Indian country heard Peter McDonald, Chairman of the Navajo Tribe, address the Senate Select Committee oversight hearings on Public Law 93–683 in Albuquerque, N.M., wherein Mr. McDonald described many of the problems that Indian Tribes had encountered with the Bureau of Indian Affairs and its implementation of Public Law 93–638. At the conclusion of this testimony, Mr. McDonald remarked that "whatever I have said about the Bureau of Indian Affairs and its problems to implement Public Law 93–638 should be multiplied 10 fold with respect to the Indian Health Service." The National Urban Indian Council can now see that Mr. McDonald was indeed justified in his doubts concerning the inadequacies of the Indian Health Service. It is our hope that through our testimony, members of this committee can also appreciate the prophetic nature of Mr. McDonald comments.

Mr. Chairman, members of the committee and staff, the National Urban Indian Council would like to make the following recommendations as it relates to section 701 of Public Law 94–437 of the Indian Health Care Improvement Act:

Recommendation No. 1

We would recommend that in the future Congress not entrust IHS with simple responsibilities that they are incapable of carrying out, even if merely a statistical survey.

Recommendation No. 2

NUIC would recommend that the Congress recognize that the urban Indian statement of need prepared by the Indian Health Service is grossly inaccurate.

Recommendation No. 3

We recommend that Congress recognize the incompetence of IHS as it relates to off-reservation American Indians and Alaska Natives.

Recommendation No. 4

We would recommend that Congress prepare its own report on the unmet health needs of the Urban Indian population, with the assistance to include but not be limited to the Bureau of Indian Affairs, U.S. Department of Labor, U.S. Department of Housing and Urban Development, U.S. Department of Health Education and Welfare and within, HEW, even IHS.

Mr. Chairman, members of the committee, and friends, on behalf of the National Urban Indian Council I thank you for your time and wish the best in your efforts.

NATIONAL URBAN INDIAN COUNCIL

To promote the social and economic self-sufficiency of Native Americans.

Document # 1

N.U.I.C.

October 2, 1978

[illegible] Region II
[illegible]
Vice President
[illegible] Region IV
[illegible]
Treasurer
[illegible] Region III
San Diego, Ca.
Secretary
[illegible] Region VIII
Bismarck, N.D.
[illegible] Region I
[illegible]
[illegible] Region II
[illegible]
[illegible] Region III
[illegible]
[illegible] Region V
St. Paul, Minn.
[illegible] Region VI
Oklahoma City, Ok.
[illegible] Region VII
Sioux City, Iowa
Attorneys - Region I
[illegible]
Omaha, Nebr.
Attorneys - Region II
[illegible]
New York, N.Y.
Attorneys - Region III
[illegible]
Philadelphia, Pa.
Attorneys - Region IV
[illegible]
Fay, N.C.
Attorneys - Region V
[illegible]
Detroit, Mich.
Attorneys - Region VI
[illegible]
Hendersonville, Ok.
Attorneys - Region VII
[illegible]
Omaha, Ne.
Attorneys - Region VIII
[illegible]
Helena, MT.
Attorneys - Region IX
[illegible]
Los Angeles, Ca.
Attorneys - Region X
[illegible]

Dr. Emery Johnson
Director
Indian Health Service
Department of HEW
Room 5A55
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. Johnson,

Pursuant to the meeting between the National Indian Organization Consultants to IHS for P.L. 94-437 and Key IHS Staff, August 14-15, 1978, at IHS Headquarters in Rockville, Maryland, it was learned that contracts are being negotiated with 10 urban Indian organizations for initial funding by IHS with Title V funds.

As you may know, National Urban Indian Council has been contracted by the Department of Labor to assist urban Indian organizations to obtain funding for services for off-reservation Indian people. Would your office please supply us with the names of the organizations which IHS has awarded Title V funding in F.Y. 1978? Any information you could send us in this area would be greatly appreciated.

Sincerely,

Gregory W. Frazier
President

GWF/af
cc: B. White
E. Hallmark

NATIONAL URBAN INDIAN COUNCIL

To promote the social and economic self sufficiency of Native Americans.

Document #2

N.U.I.C.

President
Gregory W. Frazier Region X
Seattle, Wa.

Vice President
M. L. "Lindy" Morton Region IV
Birmingham, Ala.

Treasurer
Randy Edmonds Region IX
San Diego, Ca.

Secretary
Elizabeth Hamilton Region VIII
Bismarck, N.D.

Trudie Lamb Region I
Meriden, Conn.

Minnie Gordon Region II
Syracuse, N.Y.

Clara R. Nye Region III
Middletown, Pa.

Amos Simmonds Region V
St. Paul, Minn.

Barbara Minor Region VI
Oklahoma City, Ok.

George Sims Region VII
Sioux City, Iowa

Attorneys Region I
Mary Hoxie
Orono, Maine

Attorneys Region II
Mahlon Swift
New York, N.Y.

Attorneys Region III
William Lynch
Philadelphia, Pa.

Attorneys Region IV
Agnes Holman
Troy, N.C.

Attorneys Region V
Agnes Holman
Detroit, Mich.

Attorneys Region VI
Avery Mirage
Hopkinsville, Ok.

Attorneys Region VII
Alfredda Mark
Omaha, Ne.

Attorneys Region VIII
George Horsted
Helena, MT.

Attorneys Region IX
Earl Boyd
Los Angeles, Ca.

Attorneys Region X
Walter Gamble

October 2, 1978

Office of the Director
Aberdeen Area IHS
Federal Building
Aberdeen, S.D. 57401

Dear Sir:

The National Urban Indian Council would like to thank you for sending us current information regarding P.L. 94-437. As you may know, we are a national organization and our urban constituents have a vested interest in the future of 437.

This is the only information of this nature we have recieved for some time. Had it not been for your office we probably would not have recieved any at all.

We hope you will continue to send us all relevant information pertaining to P.L. 94-437 and off-reservation and urban Indian issues.

Sincerely,

Gregory W. Frazier
President

GWF/af
cc: B. White
E. Hallmark

65-481 O - 80 - 8

NATIONAL URBAN INDIAN COUNCIL

To promote the social and economic self-sufficiency of Native Americans.

Document #4

N.U.I.C.

President
Gregory W. Frazier - Region II
Everett, Wa.

Vice President
C.L. "Turtle" Wilson - Region IV
Birmingham, Ala.

Treasurer
Tandy Edmonds - Region IX
San Diego, Ca.

Secretary
Elizabeth Hootch - Region VIII
Edmonton, N.W.

Trudie Lamb - Region I
Meriden, Conn.

Annie Carron - Region II
Irvington, N.Y.

Lena R. Yost - Region III
Williamsport, Pa.

Jerry Stevenson - Region V
St. Paul, Minn.

Arlene White - Region VI
Oklahoma City, Ok.

George Bent - Region VII
Sioux City, Iowa

[illegible] - Region I
Old Town
Orono, Maine

[illegible] - Region II
Alfred Bush
New York, N.Y.

[illegible] - Region III
[illegible] Lynch
Philadelphia, Pa.

[illegible] - Region IV
Arlie Hardin
Ft. N.C.

[illegible] - Region V
[illegible] McGregor
Detroit, Mich.

[illegible] - Region VI
Irma Mahar
Cincinnati, Oh.

[illegible] - Region VII
Freeda Ware
Ophiem, Ne.

[illegible] - Region VIII
George Horned
Helena, Mont.

[illegible] - Region IX
Al Bowe
Los Angeles, Ca.

[illegible] - Region X
Alex Cornelius
Spokane, Wa.

October 4, 1978

Dr. Emery Johnson
Director
Indian Health Service
Department of HEW
Room 5A55
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. Johnson,

We have been apprised that IHS currently has an advisory task force. It is our understanding that this association, the National Indian Organization Consultants to IHS, was established for the purpose of advising HEW on current activities and improving communications and response systems.

National Urban Indian Council, the largest national urban Indian organization in the country, identifies, via our constituents, many of the gaps in Health Services for off-reservation and urban Indian people. Todate, NUIC has not been approached to serve on this task force. We are in an excellent position to provide IHS with input and strategy design which may currently be unavailable.

Your attention and support toward our efforts to assist all off-reservation and urban Indian organizations by serving on the National Indian Organization Consultants, would be greatly appreciated.

Sincerely,

Gregory W. Frazier
President

GWF/af
cc: NUIC Health Committee

P.O. Box [illegible] [illegible], Washington 98122

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
ROCKVILLE, MARYLAND 20857

Document #5

OCT 31 1978

INDIAN HEALTH SERVICE

NOV 07 1978

Gregory W. Frazier, President
National Urban Indian Council
P.O. Box 24764
Seattle, Washington 98124

Dear Mr. Frazier:

Thank you for your recent correspondence regarding the Indian Health Care Improvement Act -- P.L. 94-437. This letter will respond to your letters of October 2 (two letters) and 4 to Dr. Emery Johnson, Director, Indian Health Service, and of October 3 to me.

In response to your several requests:

1. We are adding the National Urban Indian Council to the "Master Mailing List" for P.L. 94-437 information and materials mailed from Indian Health Service (IHS) Headquarters to Indian organizations. However, I recommend you maintain close communication with your nearest P.L. 94-437 Coordinator for ongoing information specific to the Northwest. Thus, please contact:

   Mr. Al Cayous
   P.L. 94-437 Coordinator
   Portland Area IHS
   Federal Building Room 476
   1220 SW Third Avenue
   Portland, Oregon 97204
   (503) 221-2020

2. Enclosed is a copy of the list of the 10 urban Indian organizations which were initially funded in fiscal year 1978 with IHS Title V funds.

3. I appreciate your sending a copy of resolutions passed at the 1978 Annual Conference in Kansas City. These materials had not been received previously in my office.

4. I assume your mention of "...an advising task force." refers to the National Indian Organization Consultants to the Indian Health Service for P.L. 94-437. In view of the requirements of the Act and the fact that the IHS plans national health programs in cooperation with national Indian organizations, the Director, IHS, invited four major national Indian organizations to select a representative

Page 2 - Gregory Frazier

to serve as a consultant to IHS for matters regarding P.L. 94-437. The four organizations, representing the majority of Indian people and their local and regional leadership, are the American Indian Health Care Association (AIHCA), National Congress of American Indians (NCAI), National Indian Health Board (NIHB), and the National Tribal Chairmen's Association (NTCA). All four organizations selected a representative who met with the IHS Core Team and other staff periodically during fiscal years 1977 and 1978 -- to provide consultation regarding P.L. 94-437. This mechanism has proven to be a specially effective way to stimulate input and share communication among the national Indian organizations and the IHS. The reports issued after these meetings and distributed throughout the "437 usual distribution" enable all interested organizations and persons to share in the results of the meetings. Because of the vital role the consultants have performed in the planning and implementation of P.L. 94-437, the following conclusions exist:

a. The National Indian Organization Consultants to the IHS for P.L. 94-437 will continue to meet periodically with key IHS staff as long as the meetings are needed, productive, and effective.
b. There is no reason to change the organizations involved in this consultative process.

Let me emphasize, of course, the National Indian Organization Consultants to the IHS for P.L. 94-437 is one of many ways that maximum participation of American Indian and Alaska Native people is and will continue to be, secured in the planning, implementing, and operating of all aspects of P.L. 94-437. Therefore, any advice and assistance the National Urban Indian Council can provide to the IHS, both at the Area/Program Offices and at the Headquarters Office, will be greatly appreciated.

Sincerely,

Robert C. Birch

Robert C. Birch, D.D.S.
Project Manager, P.L. 94-437
Indian Health Service

Approved:

Emery A. Johnson, M.D.
Assistant Surgeon General
Director, Indian Health Service

Attachment

DEPARTMENT OF [illegible]ALTH, EDUCATION, AND WELFARE
[illegible]IC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
INDIAN HEALTH SERVICE

IHS Area/Program Office

DATE: NOV 2 . 1978

437-14

Document #6

rector
ndian Health Service

Urban Specific Health Plans

Recent meetings and discussions have indicated that there is some confusion about who can submit Urban Specific Health Plans (USHP) for consideration in developing the Secretary's recommendations for additional authorizations for P.L. 94-437 for fiscal years 1981-1984.

It should be clear that the IHS Plan to be submitted to the Secretary's consideration in reporting to the Congress by December, 1979, as required in Title VII Section 701 of P.L. 94-437, will consist of:

1. Tribal Specific Health Plans (TSHP) and USHP consolidated into Service Unit Plans (where appropriate), Area/Program Office Plans, and the IHS National Plan. NOTE: Some USHP will be for cities not served by an IHS Service Unit, e.g. New York City, Chicago, Los Angeles, Minneapolis. In such cases, the USHP will be consolidated into the appropriate Area/Program Office Plan and, of course, National Plan.

2. A basic computation of resource needs using 1970 Bureau of Census population data projected to F.Y. 1984. These data are furnished by the IHS. In addition, the IHS National Plan will include a second set of calculations based on population data differing from the Bureau of Census data presented and justified by tribes/urban groups in their T/USHP.

Each urban Indian health project operating with P.L. 94-437 Title V funds must, as stated in their contract, prepare an USHP. However, there are many other non-tribal or non-reservation Indian groups who, because of the definitions in P.L. 94-437 and the Final Rules and Regulations implementing the Act, may qualify as urban Indian organizations. Since the IHS does not have sufficient resources to provide on-site technical assistance to the potentially large number of urban Indian groups which could request on-site help in developing an USHP, the following policy will be implemented immediately for ANY URBAN INDIAN ORGANIZATION NOT CURRENTLY FUNDED BY IHS TITLE V FUNDS:

The organization, if it meets the requirements for an urban Indian organization cited in P.L. 94-437 and in the Final Rules and Regulations (CFR 42 part 36 dated

November 18, 1978) may develop and submit an USHP to the nearest IHS Area/Program Office.

The IHS is obligated to provide to such organizations only the USHP Guidelines, Sample Plan, and similar helpful materials, and instructions for the timely submission of the USHP to the Area/Program Office — if the organizations request assistance.

The IHS is not obligated to provide any additional technical assistance nor site-visits to such organizations to assist them in developing their USHP. Of course, final decisions regarding the amount and type of assistance provided these organizations is the responsibility of the Director, IHS Area/Program Office.

Any USHPs submitted by such organizations will be included in the consolidation of all other USHPs and TSHPs and Service Unit Plans into Area/Program Office Plans and the IHS National Plan.

If you have questions or comments regarding these matters, please contact Mr. Tim Shea, IHS TSHP Coordinator (443-4724) or Mr. Wes Halsey, IHS TSHP Coordinator (443-6840).

Emery A. Johnson, M.D.
Assistant Surgeon General
Director, Indian Health Service

N.U.I.C.

NATIONAL URBAN INDIAN COUNCIL

To promote the social and economic self sufficiency of Native Americans.

Sue

Document #7

February 5, 1979

Dr. Emery Johnson,
Director
Indian Health Service
Department of HEW
Room 5A55
5600 Fishers Lane
Rockville, Maryland 20857

Dear Dr. Johnson,

On behalf of the National Urban Indian Council's Executive Committee, we would like to express our gratitude to you for meeting with us Thursday, February 15, 1979, at 11:00 AM. At this time our officers, Mr. Randy Edmonds, Treasurer, Mr. H.L. Martin, Vice-President, Ms. Elizabeth Hallmark, Secretary, and Mr. Gregory Frazier, President, will discuss with you issues which concern the social and economic well-being of urban Indian people throughout the United States.

We look forward to meeting with you in Washington, D.C. on Thursday. Until then we remain

Sincerely yours,

Gregory W. Frazier,
President

GWF/af
cc: R. Edmonds
H.L. Martin
E. Hallmark

Document # 8

TO: Gregory W. Frazier, President, NUIC

FROM: Virginia L. Wasmundt, Health Information Specialist

DATE: March 14, 1979

RE: Key Figures/Tribal & Urban Specific Health Plans

After your return from meeting with Dr. Emery Johnson, Director, IHS and Dr. Robert Birch, Project Manager, P.L. 94-437, on February 16, 1979, I called Wes Halsey, USHP Coordinator, IHS on February 22, 1979 to ask him for above subject. He said he would send me specific figures for on-reservation tribes who use P.L. 93-638 funds. He could not give me anything on urban programs. He was to respond within a week.

After a week and five days, I called him again on March 6, 1979. He did not have complete information on tribal programs, but would send me what he did have. I placed a third call to him on March 13, 1979. He was unavailable, but I left word for him to call me. I called him on the morning of March 14, 1979, he was out, so I asked that he return my call. He did call me back with the followings all of this information is computerized and it will cost $240 to obtain this material, although we are entitled to it under the Freedom of Information Act. He has sent us a letter stating such. He will send a mailing list of all urban Indian health contractors.

VW/vw

Originator
Chrono
Subject

Document #9

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES ADMINISTRATION
ROCKVILLE, MARYLAND 20857

INDIAN HEALTH SERVICE

RECEIVED
MAR 19 1979

MAR 14 1979

N.U.I.C

Ms. Virginia Wasmundt
National Urban Indian Council
Suite 525
1805 S. Bel Aire
Denver, Colorado 80222

Dear Ms. Wasmundt:

I have been informed by our contracting office that a complete list of all tribes and Indian organizations having a health planning grant or contract is available to the public upon request. However, since the required information has to be extracted from our computer terminal, there will be a charge of $250.00 for this service.

A written request for this information should be directed to:

Mr. Paul Dickerson
Office of Contracts & Grants Management
Indian Health Service
5600 Fishers Lane
Parklawn Building, Room 6A-29
Rockville, Maryland 20857
Phone: (301) 443-5204

We appreciate your interest and concern.

Sincerely yours,

Wes Halsey

Wes Halsey
Project Officer
Division of Indian Community Development

Copy to Barter and Edmonds - re: previous memo.

N.U.I.C.

NATIONAL URBAN INDIAN COUNCIL

To promote the social and economic self-sufficiency of Native Americans.

March 20, 1979

outgoing

Document # 10

MEMORANDUM

TO: George Barta and Randy Edmonds

FROM: Gregory W. Frazier, President

RE: Progress Follow-Up on IHS Meeting

I received a rather disturbing memorandum from our Health Information Specialist, Virginia Wasmundt, the staff person assigned to work with staff of the Indian Health Service, pursuant to our meeting with Dr. Emery Johnson and Dr. Robert Birch. I had briefed Virginia on the meeting that we had and she called a Wes Haulsey who is the 437 Coordinator for the Urban Specific Health Plans, I believe, on February 22nd. During the conversation she asked him for the key indicator factors that we were looking at pursuant to our conversation with Birch. He indicated to her that he could not send any information for or related to urban programs, but that he could send some figures on reservation activities who use 638 funds. He had indicated to her that he would respond within a week. The staff person has indicated in her memorandum that after a week and five days she again called him on March 6th. He indicated that he did not have complete information on tribal programs, but that he would send what he did have. A week later, having not received any information, she placed a third call to him; he was unavailable, but she left word for him to call her back. Having not received a call, she again attempted to contact him on March 14th. This time he did call her back with the following information:

> "All information is computerized and it will cost $240.00 to obtain the material altnough N.U.I.C. would be provided the information under the Freedom of Information Act."

He had indicated that he was sending a letter to Virginia stating such, and further that he would send a mailing list of all urban Indian health contractors.

Obviously, this situation has become more complex for the individual in IHS than we had assumed it would be during our conversations, as you will remember , with Dr. Birch and Dr. Johnson. I am not sure if this relates to the competence of the individual staff people back there that are to work on these projects, or their general intelligence levels, or psychological factors related to the world of work. We find ourselves in a situation now, on March 15, 1979, of not having receiving from whomever Birch was to talk to, these particular indicators that he had expressed would be desirous for extrapolation purposes. If I remember the situation correctly, we were discussing the necessity for an overall profile related to the urban specific health plan that was currently being prepared by IHS through its contracts with the off-reservation or urban 437 contractors. In the preparation of their urban specific health plans, Birch indicated that these are being prepared based upon a select geographic area by that particular urban contractor. Therefore the data that they will present to Congress in June will only reflect that which will be accumulated in those forty select geographic areas. Subsequently, areas where they do not have operating urban specific health plans, they will have no statement of need from that geographic area. What we have indicated to Birch we would be willing to help them do as well as Dr. Johnson, was come up with some information that could be used in a statistical extrapolation method to link what was found in those forty areas to the balance of the off-reservation programs so that when they go to Congress they can say, "This reflects the overall needs of the entire population," not just the Indian population that resides within the geographic areas of those forty contractors. Our obligation to them was that they would get back to us, via our staff member, what factors they were looking at, what data they needed, whether it be population basis, or income basis, or whatever, that they felt they could extrapolate to and use as a key indicator, we would be willing to provide that information.

It would appear that somewhere within IHS this has run into resistance either because of possible some of the factors sighted above.

On March 15th I placed a telephone call to Dr. Birch to see if we could not clear up the situation as quickly as possible. After an in-depth survey conducted by Dr.

Birch's telephone receptionist as to the nature of my business, I was informed that Dr. Birch would call me back. As of the end of the business day on March 16th we had still received no response from Dr. Birch.

Based upon the discussions that we had with Dr. Birch and Dr. Johnson relative to the timing of their need for key indicators, I can see no way that such can be provided by the National Urban Indian Council at this point in time.

I have had some discussion with staff members in the Senate relative to an attempt to schedule oversight hearings on 437, the Indian Health Care Improvement Act, sometime during this session of Congress. I think from a strategic basis that we should definitely plan to make presentations relative to some of the difficulties within the bureaucratic structure of IHS back at headquarters as well as make some efforts prior to that time to develop the data submitted subsequent to the submission of IHS relative to urban specific health plans.

GWF/mp
cc: Board Members, N.U.I.C.
Senator John Melcher